Post-graduate Lecture

ON

THE GREAT PRACTICAL IMPORTANCE OF SEPARATING RHEUMATOID ARTHRITIS FROM GOUT.

Delivered at the Central London Sick Asylum, Oct. 13th, 1892,

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GENTLEMEN,—Let us suppose that we are examining a diseased joint—say, a knee,—and we find it swollen and out of shape, perhaps showing evidence of containing fluid and possibly exhibiting some redness and heat of surface. These symptoms we can ascertain at once by touch and sight; but we are unable, unless we proceed further, to discover the real alterations which have taken place in the articulation or to know the condition of system which has given rise to the morbid state of the joint. 1. It may possibly have arisen from some accidental sprain which has excited traumatic inflammation of the joint. 2. A gouty condition of the system may be the cause. 3. It may be the result of true articular rheumatism. 4. Pyæmia due to the presence of pus in the blood may have caused the appearances we have noticed. 5. It may be the result of what may be termed "urethral rheumatism"—a disease in many respects allied to pyæmia, and connected with the formation and absorption of a specific form of pus. 6. It may arise in a condition of the system which may be termed "rheumatoid arthritis"—a condition which I shall have occasion to dwell upon in this lecture, and which therefore I need not speak further of at present. In order to have a chance of combating with success the various forms of articular disease, it is absolutely essential that we should have a clear insight into the various pathological changes which the different structures exhibit when carefully examined, and likewise a knowledge of the many morbid conditions of system in which they may occur.

Having but a single hour at my disposal I think I shall spend it more profitably in attempting to clear up one or two points of great practical importance rather than in treating of many in a less complete and satisfactory manner. That the points I have chosen are of the greatest importance may be gathered from the fact that hundreds, probably thousands, of patients have been reduced to a crippled state simply from want of rightly understanding them. The subject I shall select is the differential diagnosis of true gout, and an affection, formerly, and even now, by many medical men termed "rheumatic gout." The study of articular affections some thirty years ago led me to the conclusion that the majority of the cases then called "rheumatic gout" were related neither to true gout nor true rheumatism, and that they had an independent pathology of their own; and if such is the case, the term "rheumatic gout" was doubly wrong. I must confess that even before I proposed to change the name of the disease it struck me as very peculiar that there should be such a compound malady; it would have appeared to me no more surprising to hear of scarlet-fever-measles or any other combination of diseases. I proposed the name of "rheumatoid arthritis"—a name which does not imply any error, but assumes the disease to be an arthritic or joint disease having some of the external characters of rheumatism,—and the name has of late years been very extensively used, nor should I wish to alter it, although I allow that a better name may one day possibly be found. Arthritis deformans has been applied to the malady, and this again is not an erroneous name, though in the earlier stages of the disease it is by no means a characteristic one. The term "rheumatic arthritis" is nearly, or at least half, as bad as that of "rheumatic gout," as it implies the existence of one error instead of two. I am not aware of any two joint affections which are so frequently mistaken for each other as gout and rheumatoid arthritis, and I know of no errors of diagnosis which have led to so much mischief; nor is it difficult to understand why such terrible results are apt to follow, seeing that both the medicinal and dietetic treatment so useful in the one disease may prove most injurious in the other. My case books, even of the last ten years, contain fearful instances of the ill effects which may arise from such errors of diagnosis; and if in the present lecture I am able to prove to you the truth of these statements, I shall feel that I have not devoted my allotted hour to a useless purpose.

Before selecting actual cases of these diseases and pointing out the way in which one may be separated from the other, it will be necessary for me to bring before your notice the principal features which characterise both gout and rheumatoid arthritis. This I shall endeavour to do in as few words as possible; and first we shall speak of gout. You have probably been accustomed to hear gout spoken of as simply a joint affection, in which occasionally the disease is transferred either from one joint to another, or sometimes from a joint to some other organ. This was my own idea a few years ago; but a very extensive experience has disposed me to look upon gout as a systemic disease, invariably connected with a peculiar and characteristic state of the blood, which I shall shortly describe, and to consider that it may and does frequently exist for many years without the development of any joint affection, but confining itself to the production of changes in numerous other tissues and organs. The characteristic features of gout may be thus described:—1. In all cases of gout, articular or not there is an excess of uric acid in the blood. 2. The tissues of the joints which have been subjected to gouty inflammation always exhibit deposits of uric acid in the form of the biurate of sodium in a crystallised state, and this deposit must be looked upon as the cause, not the result, of the inflammation—in other words, the deposited urate is antecedent to the inflammatory action. 3. The inflammation which occurs around the deposited urates produces a destructive action upon them. 4. Gout is often manifested in non-articular structures, as the skin, kidneys, bladder and prostate, throat, digestive organs, muscles and so forth. 5. (*a*) Gout has a close relation to the patient's diet, especially to his alcoholic beverages; (*b*) gout is much more common in men than in women; (*c*) gout is a strongly hereditary disease. We must now discuss at least some of these different statements.

1. Many years have now elapsed since uric acid was discovered in the blood. In June, 1847, I procured the blood of a patient suffering from a severe attack of typical gout, and on carefully examining the same was enabled to separate uric acid from it, either in the form of the crystallised acid or as the biurate of sodium. These researches were published in the Transactions of the Medical and Chirurgical Society in 1848 and following years. It may perhaps be well to mention that at the time I made these observations there was no difficulty in procuring a sufficiency of blood; venesection was constantly performed and even looked for by patients who had any inflammatory disease. At the present time it would be practically impossible to make such investigations as I then was enabled to pursue.

2. A proof of the truth of our second statement—namely, that the deposition of urates in the tissues is antecedent to the occurrence of the inflammatory action—is seen during the formation of the little bodies which so often occur in gouty subjects in the helix and other parts of the external organs. At first we observe a little vesicle; the contained fluid is almost transparent; this fluid gradually becomes more or less opaque or milky, then creamy; afterwards the consistence gets cheesy, and lastly chalk-like in its hardness. In by far the great majority of cases these deposits in the ear are unattended with any inflammation; there are, however, well-marked exceptions to the rule. Every post-mortem examination shows the uniform occurrence of urate deposits whenever any joint has been attacked with gouty inflammation, and I was enabled to show the deposits in two interesting cases: one that of a man who during life had two distinct attacks of gout confined to the ball of one great toe, and in this subject examination showed the deposit in this joint only; the second case was also that of a man who had but one attack thirteen years before his death, and in this instance the deposit was found in parts known to have been implicated during life, and in these only. Extensive deposits of urates are often found in the bursæ or the elbows, which at times are unaccompanied with inflammation.

3. If a large joint, such as a knee, which has been often subjected to gout be examined after death, it will be seen that the deposits on the synovial surface do not approach near to the bloodvessels, which would seem to show that the bloodvessels of the inflamed surface have caused the partial

destruction of the previously deposited urates. That the blood of any tissue in a state of gouty inflammation contains less uric acid than that of any other part of the same subject is not difficult of proof and may be easily shown by the application of a blister to the part. I have found, for example, that the fluid from the inflamed dorsum of the hand has been free from uric acid when that from the chest of the same person was rich in that acid. The slight inflammation caused by the blister itself to some small extent destroyed the uric acid.

4. In the non-articular manifestations of gout, which are far more numerous and frequent than I was formerly disposed to admit, and which are perhaps less frequently found in hospital practice, the parts most commonly affected are the following:—

(*a*) *The Skin.*—Now and then, in gouty conditions, we find different varieties of erythema. It may, however, be questioned if this cutaneous affection is more frequent in gout than in many other diseases—it is certainly much less common than in rheumatism. Eczema, on the other hand, is the skin disease which is so characteristic in gouty subjects; it presumably occurs before the articular manifestations and becomes relieved by their occurrence; but it often remains during the course of the joint disease, and at times continues for an almost indefinite period afterwards. It is not uncommon to meet with eczema in the children of gouty parents, even when they are still quite young. On the other hand, it is often the bane of gouty subjects in the latter years of their lives. The production of eczema is doubtless a means of getting rid of uric acid from the blood; but, contrary to what might have been at first supposed, the fluid of eczema contains no urates. This is easily explained, for each vesicle, the product of inflammation, causes the destruction of the acid, which is converted into other products. I have as yet failed to discover uric acid either in the liquid exudation of acute eczema or the scales from the surface of the dry variety.

(*b*) *The kidneys.*—The kidneys are perhaps equally as liable to be attacked, but certainly not so early in the disease, as the skin. Traces of albumen are most common in the urine of gouty patients, often most minute in quantity, but still indicating the presence of some gouty action, and of a deposit of urates in the intertubular structures. In the early stages I frequently found albumen to be quite absent during the complete intervals of gouty attacks. With regard to the occurrence of gravel and calculus, it may be remarked that some gouty subjects are troubled with calculi, and the children of such are rather liable to this malady. My friend, Sir William Roberts, has well said in his recent Croonian Lectures that "many gouty people are never troubled with gravel, and conversely that many subjects of gravel are never troubled with gout. In both complaints there is an aberration of uric acid; but the error is essentially different in the two cases, both in regard to its site and to its nature." Albumen in the urine is doubtless often caused by a gouty change in the kidney; but, on the other hand, albuminuria from any cause will certainly predispose to the production of a gouty state of the system.

(*c*) *Muscular system.*—The voluntary muscles are often affected in gout in the form of cramps, and this symptom can sometimes be made use of as a diagnostic mark. Nothing is more common than to find patients complaining of cramp in the calf of the legs, and feet early in the morning for days and weeks before the commencement of an attack of joint affection, which passes off at once when the articular inflammation comes on. My experience would lead me to think that the involuntary muscles are not very frequently affected in gout. The heart is supposed to be so at times, but true spasm in an otherwise healthy heart it has not been my lot to become acquainted with. Lumbago and other forms of the so-called muscular rheumatism are very frequently associated with a gouty state of the system.

(*d*) *Digestive organs.*—For weeks, months and even years, before an attack of gout in the joints it is not unfrequent to find patients suffering much from indigestion, usually of an irritative character, often accompanied with much flatulence, pain, red tongue and hæmorrhoids—symptoms indicating that the mucous membrane of the stomach is slightly inflamed, and that the portal vessels are in a state of congestion. I have also thought that gouty patients are very liable to have a loaded state of the colon and fulness of the liver; but whether this condition is more common in gouty than in other subjects I could not positively say. When gout has been induced by the mode of living it is probable that the whole portal system has been also disturbed by the same cause. The throat, nose, prostate gland and testicles are at times implicated in gouty patients. Sore-throat is exceedingly common and often alternates with other manifestations of the disease. The tonsils usually exhibit a peculiar purplish colour, without showing any appearance of acute soreness. In a very few cases I have seen the end of the nose unmistakably affected by gout, causing great inconvenience and suffering. The prostate gland is not unfrequently attacked, and its gouty character can be easily seen after a time by the quick subsidence of the symptoms, especially if a large joint becomes inflamed. In several cases I have seen one or both testicles attacked with gouty inflammation.

(*e*) *Circulatory and respiratory systems.*—There is a very prevalent idea in the profession, as well as amongst the public, that the heart is often attacked by gout, and there are records of many men, some of considerable eminence, who have died suddenly from this cause. I have never myself seen acute pericarditis or endocarditis brought on during an attack of articular gout. Doubtless the subjects of gout very frequently have chronic valvular disease, as the causes which induce gout lead also not uncommonly to slow valvular changes.

RHEUMATOID ARTHRITIS.—ARTHRITIS DEFORMANS.

It will now be necessary for me to state the chief characteristics of the second disease, which we have agreed to call "rheumatoid arthritis," before we attempt to separate the two maladies from each other, or bring under your notice illustrative cases of these maladies. 1. In rheumatoid arthritis there is an absence of any excess of uric acid in the blood; in this respect it differs altogether from gout. 2. The examination of the joints which have been implicated in rheumatoid arthritis fails to exhibit any evidence of the presence of biurate of sodium, either on the surface of the cartilages or in the surrounding articular tissues. 3. On the other hand, even in the earlier stages of rheumatoid arthritis, there is a marked alteration in the cartilages; there is ulceration from the very first, and in time the bones become completely denuded. In one instance a man under my care in the hospital had the inter-articular fibro-cartilage of the left maxillary joint completely removed, the surface of the maxillary bones denuded and the projection of bony prominences fitted so closely as to cause complete locking of the jaw. 4. Rheumatoid arthritis, as far as my knowledge of the disease at present goes, manifests itself only in the joints. We have no evidence of the existence of any morbid state of the blood. There is in all cases some defect of nutrition which appears to affect such tissues as the cartilages, which are comparatively free from vascularity. In this respect it differs completely from gout, where so many organs of the body may be implicated. 5. There certainly is a close connexion between rheumatoid arthritis and the state of the nervous system. Severe and long-continued mental depression is a very fruitful cause of the disease; but physical causes, such as frequent losses of blood, will also lead to its development. 6. There is no known relation between the condition of the kidneys, skin or digestive organs and rheumatoid arthritis. 7. The selection of the joints which become implicated in rheumatoid arthritis differs much from what is seen to be the case in gout. A knowledge of this fact is often of much use in arriving at a diagnosis. If a first attack begins in the great toe specially it is highly probable that the case is one of true gout; the frequency of its occurrence in this locality is so great as to render the symptom almost pathognomonic. There are, however, a few exceptions which must be carefully investigated when they occur. There is a special tendency in rheumatoid arthritis to an affection of the jaw and also the back of the neck; the number of cases in which one or both of these parts are attacked is very great. I should imagine at least two-thirds of the patients affected with this disease experience these symptoms during its course. At times, however, the neck may become quite set from an ankylosis of some of the cervical vertebræ, and occasionally the jaw becomes so rigid as to require the removal of a tooth in order that nourishment may be introduced into the mouth. There is scarcely any other disease in which these symptoms are found; so that their occurrance is of great value in the diagnosis of this malady. 8. The effect of diet in rheumatoid arthritis is much less marked than in gout. I am not aware of any special articles of diet influencing the progress of rheumatoid arthritis when it is present, or leading to its first development. It may be regarded as certain that any diet which is insufficient to keep up re

the general health leads to the increase of the disease; and, on the other hand, any diet which improves the strength tends to lessen the affection. With regard to alcoholic beverages, I may remark that malt liquors, port, sherry, champagne and other wines, so potent in the production and keeping up of true gout, have no influence in causing rheumatoid arthritis. This I shall be able to prove to you before the end of the lecture. Total abstainers are quite as liable to rheumatoid arthritis as those who have taken ordinary alcoholic drinks. I have had many cases illustrating this point—one a clergyman who had never in his life tasted alcohol, and whose father and mother had been rigid abstainers. 9. Females are more liable to rheumatoid arthritis than males, and there can be no doubt that the influence of heredity is very much less marked in rheumatoid arthritis than in gout. 10. Rheumatoid arthritis may occur at any age. I have seen a well-marked case in a child of three years and a half old; I have also seen it commence in patients eighty-seven years old; but the more common time is from about fifteen to thirty years. Gout, on the other hand, is much more commonly met with after forty years of age.

Having brought before your notice the chief characteristics of the two maladies which engage our attention in this lecture, I shall endeavour to point out such diagnostic marks of each disease as will enable us, with something like certainty, to separate the one from the other. I must here repeat that I consider it a matter of extreme importance to form a correct diagnosis, and that the failing to do so must not be looked upon as a mere pathological error, of consequence only from a scientific point of view. To mistake true gout for rheumatoid arthritis is, perhaps, of comparatively little importance; it might, and probably would, by the treatment adopted, lead to a prolongation of the attack and inconvenience to the patient; but to mistake rheumatoid arthritis for true gout is often the cause of irreparable mischief, and may lead to the worst form of crippling. Yet I feel absolutely certain that this is daily done with the most disastrous results. It is only this day on which I am writing these lines that I have met with two new cases thus mistaken. A few years ago I was written to by a physician of very high repute, a gentleman who had been for many years connected with one of our largest hospitals. The substance of his remarks was as follows: That he had been extremely interested in reading what I had made out concerning the two diseases we have been considering, but he practically allowed that up to that time he had in his practice failed to recognise the distinction, and had acted accordingly. It must therefore be admitted that physicians, who in most respects are fully up to their profession, may be in grave error in reference to the separation of gout and rheumatoid arthritis. This was certainly the case but a comparatively few years ago. In the moderately advanced stages of true gout, when chalk stones are visible either on the helix of the ears or bursa of the elbow or other parts, it is difficult to see how any error of diagnosis can be made, for urates are never deposited except in true gout. I must direct your attention to the fact that deposits often occur in the external ear before they are visible in other parts of the body, and this may become very important in diagnosis. In many cases I have been materially assisted by attending to this pathognomonic sign.

In the early stages of gout the diagnosis is, as a rule, very easy: the suddenness of its invasion, often during the night; the acuteness of the pain; the joint most frequently affected; the short duration of the attack, usually not more than ten days; the history of the case as to diet, and more especially as to the character of the alcoholic beverage; the presence or absence of hereditary predisposition—these taken together are usually sufficient to ensure a correct diagnosis. There are, however, cases of true gout occurring in elderly people, more especially in women—they often affect the knee or other large joint—in whom the inflammation is by no means acute, but the joint remains a long time affected. These cases are difficult to diagnose correctly. The effect of treatment in such cases assists greatly in the diagnosis. The fear, however, is usually not that true gout may be mistaken for rheumatoid arthritis, but that cases of this latter disease may be looked upon as of a gouty character. This error is infinitely more common and infinitely more serious than the other. Let us take as an example the case of a young woman who is suffering from inflammation of the ankle, wrist or hand, with little, or at any rate no great, constitutional disturbance. From my experience cases of this kind are constantly looked upon by many practitioners as of a true gouty nature, and are treated accordingly. Moderate attention to the character of true gout and of rheumatoid arthritis would enable anyone to form a correct diagnosis. In such a case we should in all probability fail to find evidence of any hereditary predisposition or of any habit of the patient likely to lead to gout—for instance, the absence of eczema, cramps, kidney mischief and other gouty symptoms. We have, in fact, an alteration in one or more joints which, as far as we can make out at present, constitutes the disease. The treatment is usually of the following character: abstinence from meat (red meat especially), sugar and all alcoholic beverages. Many patients are not allowed vegetables, and fruits are often altogether prohibited. As far as medicinal treatment is concerned, salines, iodide of potassium and colchicum are most frequently administered. Under this treatment, accompanied as it frequently is by long immersion in baths, the invalid almost invariably gets worse, new joints become affected, and not infrequently the patient becomes gradually crippled.

I will first bring before your notice a few cases of rheumatoid arthritis illustrating most of the statements I have made about this disease, some of them showing the fearful effects produced by wrong treatment; others the marked good obtained by appropriate medicine and food. The following case is most instructive:—

CASE 1.—A girl nearly nineteen years of age came to me in October, 1891, in the following condition and with the annexed history. She had no hereditary predisposition to gout, and had up to seventeen years of age been in good health, but then she became weak, tired on exertion, and generally out of health. After about three months some swelling of the feet and ankles came on. She was then sent to a mineral water institution, where she remained three months under treatment. During this time the left elbow and hands became implicated, and soon after her return home one knee. When I saw her she looked somewhat emaciated and pale; the pulse was 84, small and weak. Besides the mineral water treatment she had been kept decidedly low; no meat nor stimulants being allowed. The left elbow was much injured, could neither be fully extended nor flexed; the right knee was limited in its movements, but less injured than the elbow. I prescribed for this patient the syrup of iodide of iron, to be taken twice a day, and two sulphur lozenges at bedtime, with two teaspoonfuls of cod-liver oil. As to diet, I ordered her to have daily a good amount of meat together with bread and vegetables, and with her solid food she was to take a moderate quantity of good stout. Between nine and ten months afterwards I again saw this patient, and her condition had wonderfully improved; all the functions were healthily performed and she had gained health in every respect. I suggested that she should persevere with the treatment, with the addition of five minims of the solution of arseniate of soda to the iodide of iron; the diet was to remain the same, and to include the cod-liver oil.

Now I think we may learn something from this case. I cannot say if it was called a gouty case, but certainly the treatment was most injudicious. Under the influence of the bathing, the absence of meat and stimulants, the disease made rapid progress, and joints previously free became implicated, and some, I fear, permanently injured; even shortly after her return home there was still a tendency to further mischief. Anyone examining this case, unless lamentably ignorant, must have felt assured that it could not have been of a true gouty nature. The absence of hereditary tendency to gout, the age and sex of the patient, are alone sufficient to negative the idea of true gout, even in the early stages, and the subsequent injury to the joints at once pointed out its true nature. This case is also instructive as showing the effect of diet and medical treatment. The lowering effect of the treatment produced by the baths and the poor diet was well seen, and, on the other hand, the rapid and marked influence of the tonic treatment and the meat diet and stout were equally apparent. Quite recently (three months after having last seen the patient) I have heard of a still further improvement in all respects from her father, a medical man, who fully recognises the error which was made in his daughter's case, but who had naturally entrusted her treatment to other hands than his own. Had this young lady been put under her present treatment a year before she would in all probability have been spared her injured elbow and knee, which at the best can only be alleviated, as some ulceration of cartilages has doubtless taken place.

I may remark that this patient had the characteristic jaw and neck affection well marked.

The following is another instructive case.

CASE 2.—Mrs. ——, aged thirty-three, married, no children. Seen March, 1889. Has had slight pain in different limbs for five or six years; but about four months ago the hands became swollen and cannot now be fully closed; they are also somewhat painful. The elbows are slightly implicated, as also the wrists. There is the characteristic affection of the neck and jaw; the right knee is a little swollen and stiffish; all the pains are worse while the patient is in bed. For some years there have been hæmorrhoids, which have bled much at different times. The pulse is small and quick, and there is some anæmia. This was a well-marked, but not very advanced, case of rheumatoid arthritis. The patient was put under a treatment I frequently adopt, and the progress of the case was as follows: In July the right knee had become straighter and the general health had improved; there had been an operation for hæmorrhoids in May, which had stopped the loss of blood and thus taken away any constant source of debility. In October much improvement had taken place, although she still suffered from her knee and ankle; no new joint had been attacked since she began this treatment. In April, 1890, she was fairly well. In December, 1891, she was remaining well, but had not taken much medicine, except that she had continued regularly the sulphur lozenges. In May, 1892, the patient still remained well; also in July.

This case is a good example of the value of a tonic treatment in rheumatoid arthritis. I feel absolutely sure that had the true nature of the disease under which she suffered been mistaken and had she been treated in a way supposed to be desirable in gouty conditions of the system, she would long ere this have become a cripple. The treatment adopted consisted mainly of syrup of iodide of iron and small doses of arseniate of soda, sulphur daily in small doses, cod-liver oil, a generous meat diet and claret with the meals.

CASE 3.—A man aged fifty-five, after having had bronchitis for some months, which had lowered his system and caused him to relinquish his occupation, noticed that his hands were becoming stiff; the small joints were large, tender and painful, the wrists stiff, the elbows limited in movement and incapable of either full extension or flexion; there were also well-marked stiffening and pain at the back of the neck, and especially of the right maxillary articulation. The hips were affected so as to prevent him from crossing one thigh over the other, and the knees were somewhat stiffened. This was a case not unlikely to be taken for one of gout. The age and sex of the patient were somewhat in favour of that idea; but the gradual coming on of the disease and the mischief done to the joints were, on the other hand, much against it. He was sent to a well-known mineral water establishment and went through the course, but to his surprise had not found any relief. On the contrary, he was rather worse for the treatment, and the disease was slowly but very steadily on the increase. The injurious effect of this treatment was in favour of its being rheumatoid arthritis. In such a case all lowering treatment is sure to be followed by an aggravation of the disease, and the only chance of arresting it is the steady perseverance in a proper tonic medicinal treatment and diet, and, in fact, everything should be done to sustain the general health at the highest possible pitch. Colchicum and all such drugs should be avoided.

The following is an instructive but terrible case:—

CASE 4.—A young lady aged twenty-four. This patient when she came under my notice was in the following state: Nearly every joint in the body was ankylosed; her neck was quite fixed; she was unable to turn her head in the least degree from side to side; her lower jaw was quite set fast, and she could only be fed from the absence of one or two teeth allowing a tube to be introduced for the purpose of giving nourishment; the elbows were perfectly fixed at about right angles, the wrists were rigid and the fingers curved inwards and unable to be either further flexed or extended; the knees were fixed at a right angle and the ankles and feet more or less useless. I cannot call to mind ever having met with a more complete cripple; she could not attempt to stand, and she was obliged to be propped up with pillows when she was placed in an armchair. The history of this case was most lamentable. She had been suffering from well-marked rheumatoid arthritis for some months, but still was able to walk about. She was persuaded, or her friends advised her, to try the effect of Turkish baths. She went to a hydropathic institution, where she remained thirteen weeks, and during that time had always one Turkish bath, often two, a day; it was during this lowering treatment that joint after joint became ankylosed, and she was reduced to the state of utter helplessness which I have described. I must add here that it has been my lot to have seen many cases of rheumatoid arthritis which have been very seriously made worse by the use of these baths. I do not consider that they act injuriously by their effect on the skin, but by their causing great debility and prostration of the system. This is a point to be thought of carefully when an idea of ordering baths in this disease is entertained.

CASE 5.—A gentleman aged forty-nine was seen in July, 1869. He had no marked hereditary predisposition to any disease. For about nine months the left shoulder had been troublesome, and from that time the disease gradually progressed; the right shoulder, back of neck, jaw, elbow, wrists and hands, knees, ankles and feet were one after the other affected; in some of the joints the movements were limited, as the elbows, which could not be fully flexed, extended or rotated; the patient had become thinner and somewhat pale. He was put upon a tonic treatment and took iodide of iron with much benefit, also a nutritious diet. He persevered in this treatment for some years, going to Aix-les-Bains two or three times and once to Schwalbach. He steadily improved, although I must confess at first I much feared he would become crippled. I saw him in September, 1888, nineteen years after his original visit, and he was then quite well. No case could possibly have been more satisfactory than this one. From the first he had the characteristic symptoms of the jaw and neck stiffening and was altogether in a very unsatisfactory condition. His complete recovery and his remaining well for so many years must be attributed entirely to the medicinal, dietetic and hygienic treatment which was employed.

I could bring forward many very similar cases, but in most the time since recovery is of less duration. Although I have said that cases of gout and rheumatoid arthritis can generally be separated from each other without much difficulty by attention to the various characteristic symptoms of each disease, still I have no hesitation in stating that instances now and then come under our notice in which there is much obscurity, which may require a knowledge of the effect of treatment before we can feel a certainty of a correct diagnosis. I will bring before you a case of this kind.

CASE 6.—A lady aged twenty-three. She knows nothing of the health of either parents or grandparents. About nine or ten months before I saw her she had swelling, heat and pain, first of one, then of the other foot, which lasted from six to eight weeks in all; and the inflammation was confined to the ball of the great toe. She afterwards remained free from any symptoms till a month before I saw her, when the same thing occurred as at first, but this had almost subsided and there was a little tenderness only remaining. The patient was very weak, distinctly anæmic, and somewhat breathless on exertion, and a blood murmur was heard in the neck. She had suffered from eczema of the ears, face, hands and legs when ten years of age, but not of late. Catamenia deficient, pale, and not occurring more than once in two months or so. Heart sounds healthy; no marked indigestion. She had been almost an abstainer from alcohol, and had taken but little meat. Pulse small, 96. In the interval between the first and second attack the toe-joints became well, except that there was a little enlargement. What was the nature of this case? Many things would point against its gouty character, as age, sex and mode of living; but there were two well-marked symptoms which could not be passed over. The most important was the locality of the inflammation—the ball of the great toe in each foot. Now we have seen that this is the joint which is *par excellence* affected in true gout; but I have known cases of severe gout of long standing in which the great toes have never been attacked; and, on the other hand, I have seen these joints affected in rheumatoid arthritis, though perhaps never so exclusively as in the case under consideration. The previous existence of eczema was somewhat in favour of the gouty nature of the disease; but as this occurred when she was young it might not have had any relation to a gouty state of the system. The great-toe joint remaining somewhat large in the intervals between the attacks was in favour of the affection being rheumatoid arthritis, as true gout seldom leaves appreciable enlargement from a first attack. I should be inclined to think, upon the whole, that the case was one of rheumatoid arthritis. Had I seen the effect of treatment I should soon have been quite certain as to the correctness or not of the diagnosis. After a little time I may probably have an opportunity of coming to a more definite diagnosis.

CASE 7.—A lady aged fifty-nine years; she knows nothing about her hereditary predisposition, as her father died when

she was one year old, her mother when she was two years of age. She herself has had nine children, their ages varying from thirty-eight to twenty-six. For nearly five months she has suffered first from the right knee, which became swollen and painful, tender, and contained some fluid. All the functions were performed well; pulse 84, good. Such a case as this is not uncommon and the correct diagnosis is important, not only to the patient, but to the medical man, as far as his credit is concerned. It certainly was a slight case either of true gout or of rheumatoid arthritis. In favour of its being of the nature of the latter disease there were but few symptoms; the general health was fairly good; no depressing causes had been at work. The only thing in favour of it was the duration of the disease, nearly five months. Still, from the appearance of the knee-joint I could not have said which diseased condition of the system was the cause of the articular affection. A further investigation of the case will, however, enable us to come to a right conclusion. It was noted that there had been two patches of eczema, one on the left shoulder, which had disappeared; the other, a large one, on the right thigh. This rendered it very probable that the disease was gouty. Again, before the knee became inflamed she had been much troubled with cramp in the calf of the legs and also a numbness of the hands and arms on waking in the morning; both these are markedly gouty signs. As to her habits, she had usually drank sherry, and often, when nursing her children, stout. These beverages were likely to induce a gouty habit, and, taking all these circumstances into consideration, I looked upon the case as one of gout and prescribed accordingly. The treatment consisted in the administration of ammoniated tincture of guaiacum, citrate of lithia and a very small quantity of colchicum, under which the knee rapidly became better. The effusion in a fortnight could not be detected, and in a short time the patient was well, the pulse sinking from 84 to 72, and she was quite able to walk. In this case the effect of treatment became quite a diagnostic mark. Had I prescribed for her as I should have done if I had entertained the idea that the case was one of rheumatoid arthritis, I feel quite sure the disease would have increased rather than diminished, and that she would have long remained in the condition in which I first found her. Time does not allow me to speak of many cases of gout, nor do I think it is necessary to do so, as the difficulty of making a correct diagnosis in such cases is usually small, and, as I have already said, any error would be of less practical importance.

Before finishing I think I must say a few words about a term which has been made use of lately—"rheumatic arthritis." I have already said that I consider this term erroneous if applied to the disease rheumatoid arthritis, as it would imply that it had in it an element of true rheumatism, which I altogether deny, but Dr. Lane has recently tried to differentiate between true rheumatoid arthritis and what he terms "rheumatic arthritis," considering that a disease exists which is connected with rheumatism but still is not simple rheumatism. I quite think that the occurrence of true rheumatism, in the form of rheumatic fever, may be one of the many causes which lead to the production of rheumatoid arthritis; but if the induced disease has the characteristics of rheumatoid arthritis I do not think this name is appropriate. The disease may be the same whatever the causes which may have given rise to it.

In concluding this lecture I feel I must apologise for the imperfect manner in which I have treated the subject; but the shortness of the allotted time must be partly my excuse, and my own shortcomings I must not forget. I trust, however, I have been so far successful as to convince you of the intense importance of clearly diagnosing rheumatoid arthritis from true gout, and of making you realise that the health of your patients is greatly at stake and dependent on the correct knowledge and treatment of their cases. Want of time has been the only cause of my not bringing before your notice many other cases. My note-books are so full of them that their very number causes difficulty in their selection.

SUDDEN DEATH OF A MEDICAL MAN.—On the 21st ult., at the Holborn Town Hall, an inquest was held on the body of Mr. J. R. Gibson, F.R.C.S., who had been surgeon at Newgate Prison for fifty years, but was now retired. The deceased gentleman was found lying on the footway in Devonshire-street, Queen-square, on Oct. 20th. The medical evidence went to show that death was due to heart failure, and the jury returned a verdict of "Death from natural causes."

INTRA-THORACIC AUSCULTATION: A NEW DEPARTURE IN PHYSICAL DIAGNOSIS.

A paper read before the Medical Society of London on Oct. 31st, 1892,

BY BENJAMIN WARD RICHARDSON, M.D., F.R.C.P., F.R.S.

MR. PRESIDENT AND GENTLEMEN,—I had promised to bring before the members of the Medical Society of London this session a paper on Some New Researches in Synthetic Pathology, but as I was not prepared for so early a call for the paper as that which has been assigned to me I have been unable to complete it in the form in which I would wish to present it. It happens, however, that I have at hand a short communication which I have much pleasure in submitting to you, and which, because it is extremely simple and practical, will, I trust, be accepted as a substitute for the longer and more ambitious essay. I call the present essay a study of Intra-thoracic Auscultation: a New Departure in Physical Diagnosis, and I cannot introduce it to your notice better than by relating how it came into my mind and practice. A few months ago a patient consulted me who was suffering from serious and obscure symptoms referable, by the process of exclusion in diagnosis, to the upper portion of the alimentary canal. He had lost flesh to an extreme degree, was very feeble, had often a difficulty in swallowing food, at times retained food of a fluid or semi-fluid kind in the stomach for long periods, and then after suffering severe pain vomited it with difficulty, returning it in a partially digested state. I looked upon the symptoms with suspicion as possibly indicating malignant disease of the lower part of the œsophagus; but as I found he had been following an imprudent dietary I was content at the moment to regulate diet carefully and to prescribe a mixture of dilute hydrochloric acid and pepsine. He left me, to return in two months reporting himself in every respect better. He had gained in flesh, he retained food, was free from acute pain, had improved in strength and had lost the sense of weariness of mind as well as body, which had been most oppressive. He had determined to take a holiday, and I agreed with him that the change he suggested would be advantageous. I did not see this patient again for three months, when he consulted me once more in consequence of a sudden return of his worst symptoms, to which were added others pointing more decisively to œsophageal mischief low down in the tube. With difficulty he had partaken of a rather too copious meal one day previously, and soon afterwards had been seized with acute pain, which lasted until the undigested mass had been vomited with free secretion of the gum-like mucus characteristic of stricture. He was again greatly emaciated, presented a condition of circulation so feeble that I could scarcely detect the radial pulse, and the heart was so weak that it was difficult to distinguish clearly the two sounds.

I tried in this case what I have called the water-gurgle test for the diagnosis of stricture, as described in *The Asclepiad*, vol. vii., p. 332—that is to say, I got the patient to attempt to swallow fluid whilst I auscultated in the line of the œsophagus anteriorly and posteriorly. Whenever there is true stricture of the organic class I have usually found by this method a point where there is heard a loud gurgling sound on attempts to swallow, followed by a sharp noise as of a passing current of fluid through a constricted passage, and I do think there are few more characteristic points of diagnosis of stricture existing in the lower third of the tube. There was no response to this test in the present instance, and the patient expressed to me that the tumbler of milk-and-water which he had swallowed went down without his being conscious this time of obstruction. I turned, therefore, naturally to the use of the œsophageal tube—an operation which led me to the new facts I have to record. I passed along the œsophagus a medium-sized tube and ran it without difficulty down to the stomach. There was no serious obstruction at any part, but I thought I experienced some sense of friction of a very slight kind. Whilst endeavouring to be certain on this matter an idea which I had once before had in my mind, but had not before acted upon, suddenly occurred to me. Why not auscultate

through the exploring tube? At once I sliced off a portion of the free end of the tube obliquely, slipped over this sliced end the terminal part of the double stethoscope, and made in this fashion the exploring tube a continuous stethoscope. The effect of auscultating in this way was most interesting and satisfactory. I could hear soft friction of the tube against the walls of the œsophagus and was made quite sure that the friction was uniform throughout and that there was no special constriction or induration in any portion of the tube. When I passed the tube into the cavity of the stomach itself I obtained a sound new to me, like a gentle seething as of air or gas agitated in a thickish fluid and at times a gurgling sound of gas with another sound probably due to muscular contraction of the stomach itself. As the patient experienced no trouble or inconvenience during examination I had ample time for inquiry, and I leisurely withdrew the tube, noting the sounds audible in the course of the movement. In the tube at this time there were only two openings and those at the extreme end. I succeeded therefore in catching sounds at such points only as were in apposition to the openings. I withdrew the tube until the opening on the left side came in contact with that portion of the œsophagus that lies in immediate proximity with the heart. By previous auscultation of the heart over the thoracic wall I had failed to detect clearly the two cardiac sounds owing to the feebleness of the cardiac action, but now both sounds were as distinct as they would have been from a normal heart. They were not, however, the same precisely as the sounds we hear through the thoracic wall; they were duller in character, as if they wanted the resonance which is probably produced by the pleura stretched over the thoracic cavity. At the same time they were loud and were singularly distinct. By moving the tube gently up and down I could get the second sound separately from the first and *vice versâ*; but when I had the opening of the tube midway so as to compass both sounds there was not so much difference between the first and second sound as is common to that distinguishable in ordinary auscultation. I was quite prepared for all these modifications of phenomena; they corresponded precisely with what I had learned many years ago when, in combination with the late Drs. Baly and Sibson, I had seen Dr. Halford demonstrate Brien's valvular theory of the cause of the two sounds. We listened at that time directly to the sounds from an opening in the chest wall of a lower animal under anæsthesia, and detected that with such immediate auscultation the sounds were deficient in sharp resonance, and more equable in tone than was common from ordinary auscultation. It was the same now. I counted the beats of the heart very deliberately from the inside of the thorax, seventy beats per minute, the sounds and the pause in proper order and the action perfectly regular. I expected that on withdrawing the tube further out of the œsophagus it would be possible to hear a loud sibilant or vesicular murmur in respiration. In this I was disappointed to a certain extent. It was impossible to catch a murmur, even on a deep inspiration, so distinct as the murmur heard from the chest wall outside.

From these observations I have been led to the new departure in physical diagnosis in which I am anxious others should take part, and I have devoted some time to certain preliminary steps in its development. Briefly it is a means for auscultating on an extensive scale the organs of the body *from within the body*. I shall occupy most usefully the short remaining time at my command, first, by indicating the lines of research in which the plan promises to be most useful; second, the limitations of the plan and, if I may so express myself, the objections to it; and, third, the modes by which it may be improved from this its original start, so as to make it ready, safe and in its broadest sense useful.

Touching the first of these points, the method promises to be useful—I hope very useful—in the diagnosis for which I first applied it. It proved of service to me; at the moment it told me distinctly, in the case I have referred to, that there was no constriction, no induration, at any part of the œsophagus, so that the hearing confirmed the touch, or, rather, corrected it in a manner that could not have been more satisfactory. The advantage will be that stricture may be detected in its very earliest stage—the stage in which, according to my experience (unfortunately an experience specially large in this disease), there is the only chance of doing good by dilatation. The new auscultation may prove also an aid to diagnosis in diseased conditions of the stomach itself. It is certain from the sound I heard from within the cavity of the stomach that there are going on there changes of a physico-chemical kind, leading to a sort of effervescence that is distinctive in character. It is most probable there are differences of sounds connected with special fermentations, and that by study and experience these differences may become detectable at once by auscultation. Here there is an open field for research in which I have been unable as yet to enter. Again, as bearing on the stomach, the motions of that organ evidently produce sound that will admit of interpretation. A healthy stomach may possibly give forth no sound or it may give forth a definite sound when full of food, with other sounds during various stages of digestion. These are points to be inquired into and will be of curious interest. Still it is certain that in diseased conditions of the stomach a whole series of diagnostic symptoms will be learned, bearing not only on the fermentative action in progress, but on alterations in the walls, and on contractile functions. The stomach, in short, will admit of being sounded like the chest. Scirrhus affecting the stomach should easily be diagnosed by auscultation. Through the stomach it may also be possible to diagnose physically and more correctly than we now diagnose the nature of some pulsating abdominal tumours which are, as they have been since the time of William Harvey himself, a constant source of disagreement amongst physicians. With the terminal of a full-sized œsophageal stethoscope in the stomachic cavity a loud murmur from an arterial source will be detected without the interposition of pressure and an important difficulty in diagnosis removed. A third service that may be rendered by intra-thoracic auscultation is forecast in the observation I have already made respecting the detection of the cardiac sounds in conditions when those sounds are inaudible under the usual method owing to extreme feebleness of the circulation. We are called sometimes to persons in such entire collapse that it is doubtful whether they are alive or dead. The sounds of the heart are imperceptible to the ear through the thoracic walls. Here, then, is an instant and ready method of deciding whether the action of the heart is still in progress. We have a new proof either of absolute death or of continued life. In acute collapse, as after death from chloroform, we not only can institute a good diagnosis in the same manner, but we are half way, by our manipulation, towards assisting to restore life. Through the œsophageal tube, after disconnecting the stethoscopic tubes that go to the ear, we could inject a free quantity of heated water or water with oxygen peroxide into the stomach; or, if we had learned the practice correctly, we could direct a faradaic current upon the heart itself, so as to excite contraction of the right side.

The use of the intra-thoracic method may be turned to account in diagnosis of heart disease and of aneurysm of the large thoracic arterial trunks. Stricture of the œsophagus arising from aneurysmal pressure would be instantly diagnosed. These cases are often most perplexing. The pressure causing the obstruction varies, and no sufficient sign of aneurysmal murmur in the early stages reaches the ear at all times. An auscultator fortunately catches the murmur, another does not, and so contradiction upon contradiction amongst the best diagnosticians occur. By the process of intra-thoracic auscultation this difficulty would be immediately met, the pulsation would come under direct observation, and the precise seat of the pressure would be descended upon. We should hear a pulsating stricture. In heart disease itself the intra-thoracic mode of examination should be of service. By it we ought to be able, in cases of enlargement, to distinguish between dilatation and hypertrophy. The diagnosis of clot on the right side might be made clear by this plan and the differential diagnosis of valvular affection on the right or left cavities ought to be rendered absolute, when we have learned sufficient of œsophageal auscultation to discover the new distinctions of sound that will have to be made, in some cases at least, between the tone of the first and the second sounds, and shall have defined all new lines of distinction between these sounds as heard from within and from without the exterior walls of the chest. The clearest definition by this test should be obtainable also as between pericardial and endocardial friction sound and between pericardial as distinct from pleural friction.

As this is only a preliminary note I must leave untouched the subject of pulmonary auscultation by the intra-thoracic method and also that of pharyngeal exploration. The pharynx is within such easy reach it should admit of more frequent auscultation than lower parts of the œsophageal canal. Its size, too, renders it more accessible. From it we should be able to reach the apices of the lung and the greater part of the air passages from the larynx down to the bifurcation of the bronchi. Exploration of these parts will

be easy when a set of appropriate and convenient exploring instruments have been constructed, and will afford help to diagnosis of changes incident to the apices of the lungs in subclavian, innominate and carotid murmurs, and in thickenings and obstructions of the trachea and larynx.

Having given an outline of what may be gained by intrathoracic auscultation, I shall now refer to the limitations of the plan and to the objections which may be taken to it. I assume at once that this mode of research is not called for when by the ordinary auscultation diagnosis is clear. It may come in usefully in all cases where the œsophageal tube is used for exploration, but it will not be always applicable in instances where it might be useful, owing to the circumstance that many patients are unable to bear the introduction of the tube and that it may sometimes be unadvisable to subject them to it. I met with a patient last week suffering from probable thoracic aneurysm in whose case the exploration would have been most valuable; but the introduction of the tube caused so much retching and straining I was obliged to withdraw the tube before I had explored as fully as I could have wished, although what was effected was sufficient to inform me of the existence of aneurysmal murmur from the left carotid or subclavian. The explorations might also be objectionable in cases of irritable stomach or where there was severe cough or cough with hæmorrhage. I need not dwell any longer on particular points of this kind, since the whole is summed up in a sentence whenever the practitioner feels he can safely and prudently pass a tube into the stomach, then he can bring into practice intrathoracic auscultation.

The third point, the modes in which this method may be improved by mechanical means, opens up a very wide field of inquiry. I commenced my work with the ordinary flexible tube, and up to the present time I have found nothing better than a good-sized tube with a large lateral aperture at the extreme end. I have used another tube charged with several apertures an inch from each other, and this answers fairly well. Apertures are essential in these tubes; if they are not made there is little or no conduction of sound. Messrs. Krohne and Sesemann have been making tubes for me of different materials, and one of metal, of malleable nature, is good in many ways, but I have not yet obtained what is precisely wanted even in so simple an invention as this at first sight would appear to be. The best tube at this moment is the long œsophageal flexible tube with the stethoscope attached as shown to-night.

I leave now this contribution in the hands of a Society to which it has been my high privilege to communicate many of my first thoughts from the very opening of my long career. I would not on any account attach an undue importance to the effort, or look upon it as anything more than an extension of the simple act of the illustrious Laennec, when, in the Necker Hospital one day in 1816, he improvised a stethoscope out of a roll of paper and projected thereon a new science to which there seems to be no end. I put forward this addition, however, without apology, not knowing to what—small as it is at this precise moment—it may lead. In his magnificent eulogy on his master, Cullen, Benjamin Rush said: "Let no fact in medicine, however unimportant it may at first appear, be allowed to pass unnoticed by the public eye; for there are mites in science as well as in charity, and the ultimate results of each are often alike important and beneficial." In that spirit, Sir, I offer to-night, through you and my fellow colleagues of the Society, one more mite to the treasury of practical medicine.

ST. GEORGE'S HOSPITAL.—The following scholarships have been awarded for the year 1892-93:—£145 scholarship to Mr. Henry N. Coltart; £50 scholarship to Mr. Frederick G. Peck; £50 scholarship to Mr. John B. Christian. A scholarship of £65 (open to University men) to Mr. Edmund T. Fison and Mr. Arthur Trethewy.

THE NEW POLICE CONVALESCENT HOME, BRIGHTON. On Saturday last Princess Christian, attended by Colonel and Mrs. Gordon, visited Brighton for the purpose of laying the memorial stone of the new police convalescent home. Her Royal Highness was received at the station by Mr. T. Cave, Mr. C. B. Woodruff, J.P., Dr. Ewart, J.P. (the mayor), and Mr. Gerald Loder, M.P., and was afterwards accompanied to Bertram-road by an escort of Inniskilling Dragoons, where the stone was duly laid. The building will cost £6000 and will, when completed, accommodate over 600 patients.

THE RADICAL CURE OF HERNIA, WITH A DESCRIPTION OF A METHOD OF OPERATING FOR FEMORAL HERNIA.

BY W. WATSON CHEYNE, M.B. EDIN., F.R.C.S. ENG.,
PROFESSOR OF SURGERY IN KING'S COLLEGE, SURGEON TO KING'S COLLEGE HOSPITAL, ETC.

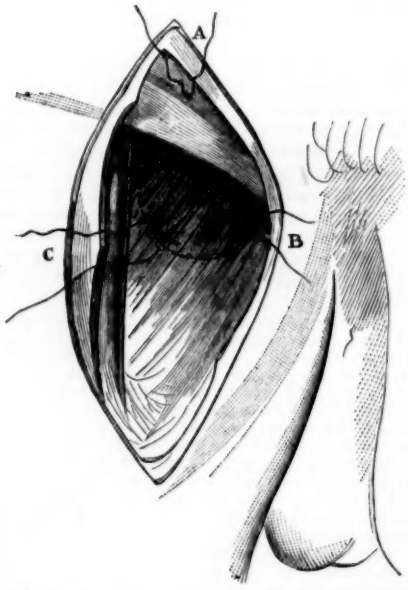
WHILE I wish to say a few words on the method of operating for the radical cure of inguinal hernia my main object in this paper is to describe a method which I put in practice some months ago for the radical cure of femoral hernia. Although the radical cure of inguinal hernia now leaves little to be desired as regards both immediate and permanent results, this is by no means the case with any of the methods which have as yet been described for the treatment of femoral hernia. Practically all the methods for the closure of the femoral canal consist, after tucking up the sac, in the attempt to approximate Poupart's ligament and the fascia over the pectineus. Now Poupart's ligament is a tense band and when stitched down to the pectineal fascia one of two things happens. In the first place, if it keeps down the tension is so great that the stitch very soon cuts its way through the ligament; in the second place, what usually has happened in my experience is that if the pectineal fascia alone is taken up in the stitch it is at once torn off the pectineus and carried forwards to Poupart's ligament, and the stitch soon cuts through the fascia. The result, in my experience, has not been at all certain and not to be compared to the result after the radical operation for inguinal hernia. On thinking over the matter, it seemed to me that the only satisfactory plan would be to turn in some tissue which would fill the femoral canal and at the same time not be subject to any tension. On looking about for material to form a flap to turn into the canal the only available structure seemed to me to be the pectineus muscle. I at first thought of turning up a flap of the pectineal fascia, but it is often very thin, and the cases in which it had been drawn forwards to Poupart's ligament were not on the whole satisfactory, and therefore I came to the decision to turn up a flap of the pectineus muscle itself. Curiously enough, although at the time that I worked out the operation on the dead body (now more than a year ago), and, indeed, at the time I put it in practice, I could find no indication that this idea had occurred to anyone else. I find in looking over the recent numbers of the *Centralblatt für Chirurgie* that on Aug. 20th, Salzer of Utrecht describes a method of turning up the pectineal fascia which he put into practice about the same time that my cases occurred, the guiding idea of which is the same as mine. He, however, uses the pectineal fascia, which I had rejected for the reasons I have mentioned, and which I feel sure will not prove to be satisfactory.

My plan of operating will be evident from the accompanying engravings. After the hernia has been reduced the neck of the sac is ligatured and stitched to the abdominal wall (A in Figs. 1 and 2). A flap is then marked out in the pectineus muscle of sufficient size to fill up the crural canal without any tension, and including the whole thickness of the muscle. The incision in the muscle begins at the inner wall of the crural canal, runs for a short distance parallel to Poupart's ligament and then curves downwards, outwards and upwards (see dotted line in Fig. 1). At the two lowest angles of the flap stitches are passed and tied so as to get a good hold (B and C in Fig. 1) of the muscle. The flap is then peeled up from the bone and the stitches (B and C) are passed through the abdominal wall, B above Poupart's ligament and C just at it. (See Fig. 2.) The result is that the femoral canal is completely filled up with a thick mass of muscle, which soon unites to the sides of the canal; and although its muscular elements may atrophy, a dense mass of fibrous tissue will be left behind. The stitches which I used were Chinese silk of medium thickness. I have operated in two cases by this method and the results are so far perfect; the region of the crural canal remains a hard mass, without the slightest impulse on coughing, and the patient does not wear a truss. I may in a few words mention the notes of these two cases.

CASE 1.—This patient, a female, aged forty-seven, was admitted to King's College Hospital on June 20th, 1892. She first noticed the swelling in the right groin three years

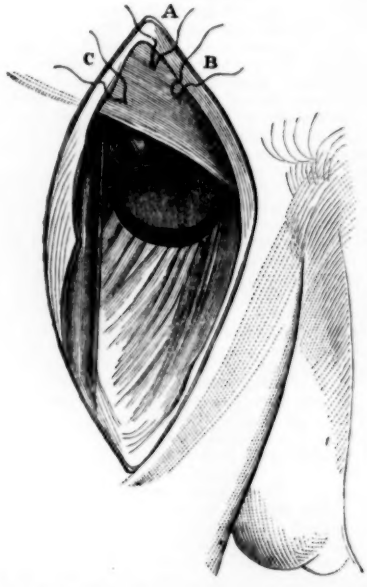
previously, and it has never disappeared; in fact, on the whole, it has increased in size. For the last three months it has been getting much larger and very painful. She also suffers from uterine trouble and ruptured perineum. In

FIG. 1.



the right groin there is a large, elastic, smooth swelling about the size of a large orange passing upwards and outwards from the region of the crural canal and in appearance resembling a femoral hernia. It is very tender and

FIG. 2.



fluctuates, and the skin is reddened over it; there is no impulse on coughing; no signs of strangulation. Various opinions were expressed as to the nature of this swelling, but I concluded that it was an altered sac of a femoral hernia. On June 21st I therefore made the ordinary incision for femoral hernia and exposed and opened the sac, which I found to contain straw-coloured fluid, the wall being covered with layers of altered blood-clot. On clearing it out it proved, as I had thought, to be an old femoral sac, the communication with the abdomen having been obliterated at the upper part of the crural canal. I then ligatured the neck as usual, cut off the sac and stitched the neck to the abdominal wall. The canal allowed the easy passage of two fingers through it, and this I closed with the pectineal flap as before described. There is nothing to remark about the after-progress of the case. The wound healed by first intention, except at the middle, where a little glairy fluid could be squeezed out at the first dressing. She was kept in bed for about ten days after the wound had healed, and was sent out on July 21st. At that time there was a hard mass to be felt in the neighbourhood of the crural canal and no impulse on coughing. She was told to wear a bandage for a few weeks, and when seen on Oct. 7th the repair seemed perfect and there was no impulse on coughing.

CASE 2.—A female aged forty-five. This patient, sent by Dr. Williams of Wood Green (who also sent the former case), was admitted to King's College Hospital on June 27th, 1892. She has suffered from right femoral hernia for eight years, and wears trusses, but the hernia is always coming down and getting obstructed, and then there is considerable difficulty in returning it. On examination I found a femoral hernia about the size of an egg on the right side, which could only be partially reduced. On June 28th a similar operation was performed to that already described. The wound healed without trouble and she was discharged on July 21st. At that time the parts were quite hard and there was not the slightest impulse on coughing, and when I saw her a few days ago her condition was perfect.

Before concluding this paper I should like to say a few words as to the radical cure of inguinal hernia, an operation of which I have had a large experience. I may say that I have tried practically every method which has been described, and no doubt several of them give excellent results. I now adopt two procedures, according to the nature of the case. Where the hernia is quite small, and where there is no great dilatation of the external oblique muscle, what I do is practically Macewen's operation, cutting off the sac and stitching it up after Barker's plan, but approximating the conjoined tendon to Poupart's ligament with silk stitches after Macewen's plan, and sometimes putting a stitch in the external ring. I may say that in performing this operation, where the external ring is not particularly large, I have found considerable difficulty in getting the hernia needles of Macewen's pattern insinuated beneath the external oblique so as to pick up the internal oblique and conjoined tendon, and in several cases the result of the attempt has been to split up the external oblique for a short distance. That, of course, is quite readily closed again by stitches, but with the view of avoiding it I have altered the shape of Macewen's needle from a curve to an angle (see Fig. 3), and this is then readily pushed up between the external and internal oblique or conjoined tendon after separating them with the handle of the knife, and then, by depressing the point before bringing it back again, it is easy to take up the latter structures. I may say that in these cases Macewen's operation is most satisfactory, and I have never had recurrence except in three or four cases where operations for strangulated hernia or for radical cure by imperfect methods had been previously adopted and where I had mainly scar tissue to work with. I believe that by the adoption of the next plan even these cases would now be successful.

FIG. 3.

Where the hernia is larger and where the external oblique has become a good deal stretched, I perform an operation which is in its essence Bassini's. After freeing the sac and returning its contents its neck is transfixed, ligatured and stitched to the abdominal wall, in the manner described by Barker. The external oblique is then slit up as far as the internal ring, the incision being carried a considerable distance away from

Poupart's ligament. The inguinal canal is thus fully exposed, and the cord is then freed from its coverings as high up as possible. It is held forwards by the assistant, and then a series of stitches are passed through the internal oblique and conjoined tendon (generally four or five in number) above and including Poupart's ligament below, in the manner introduced by Macewen. When these are tied the inguinal canal is completely closed, the only communication with the abdomen being at the point of exit of the cord, which is now above the middle of Poupart's ligament. The cord is now laid on the surface of the internal oblique and the incision in the external oblique is closed by a bootlace suture of fishing gut, sufficient hold of the tendon being taken to render it tense over the cord and only enough room being left at the external ring to allow the cord to escape. It is thus evident that for a hernia to find its way into the scrotum it must push its way through along the cord and then burrow along dense cicatricial tissue for two or three inches till it reaches the external ring. The operation as I have described it is in its essence Bassini's, but it is not carried out exactly as he describes; in fact, it is a combination of various operations. Thus the method of cutting off and tucking up the sac and the use of silk is borrowed from Barker; the principle of bringing the internal oblique to Poupart's ligament behind the cord is Bassini's, but the mode in which the stitches are applied is borrowed from Macewen; the use of silkworm gut for the incision in the external oblique is from Stanley Boyd; the bootlace suture I used myself, but I find that Boyd had also used it.

I have now performed a large number of operations by the former plan and some twenty by the latter, and, while I have lost none, the results are, as far as I can judge, perfect. In none of them, with the exceptions I have already mentioned, is there any tendency to recurrence, and those done by Bassini's method are particularly firm and satisfactory. In view of such results, which have been obtained also by other surgeons, it is curious that many patients with herniæ well suited for operation are advised to be content with a truss, and that some surgeons still say that the so-called radical cure of hernia is not really a radical cure. I can only think that the origin of the latter opinion is partly from the observation of operations imperfectly performed and partly because the patients are ordered to wear a truss afterwards. The usual fault committed in the operation is, I think, that the internal oblique and conjoined tendon are not separately attached to Poupart's ligament, but that the stitch is made to include the internal pillar and the conjoined tendon at the same time. The results of that procedure are, so far as I have seen, unsatisfactory. A much better repair of the inguinal canal is got by bringing the conjoined tendon to Poupart's ligament independently of the external oblique. I do not think that it is so much the adhesion between Poupart's ligament and the edge of the internal oblique and conjoined tendon which prevents the recurrence of the hernia as the adhesion between the external oblique and the structures beneath it in a new position, which prevents the conjoined tendon slipping up again and leaving the inguinal canal open. The second reason, I think, is that some surgeons recommend the patient to wear a truss afterwards. This is radically wrong. If the repair is properly accomplished the only effect of the truss will be to cause absorption of the new material thrown out, and I always insist on the patient leaving off all support in about two months after the operation and only wearing a light bandage up to that time.

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REMARKS ON THE SCOPE AND ORIGIN OF FIBROID PHTHISIS.

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SINCE the discovery of the tubercle bacillus an immense propulsion and show of stability have been imparted to the theory of the tuberculous origin of the several varieties of phthisis. It is held that of the genus "phthisis" there are several species whose separate features are the outcome of the different reactions which take place between the bacillus and its host. If the parasite flourishes apace and the resulting products get heaped together, and likewise rapidly disseminated through the lung, acute phthisis, commonly called "galloping consumption," is produced. If the tuberculous masses are gradually evolved and dependent chiefly on inflammatory products, ordinary caseous phthisis results; while if the tubercles are chiefly and also slowly formed in the peribronchial rather than the alveolar tissues undergo a fibroid metamorphosis, and are likewise accompanied by the growth of fibroid tissue more or less generally throughout the lung, the disease is fibroid phthisis. And it assuredly must be admitted that in this simple and well-ordered scheme of the unity of phthisis there is not only a fascination, but also the illustration of a principle which reigns supreme both in nature and in art.

Now in so far as phthisis pulmonalis is tuberculous there can, I think, be no serious objection taken to this explanation of its various phases; but many at the present time go so far as to affirm that phthisis is synonymous with a local tuberculosis in the lungs, and has no wider signification. This limitation, be it observed, is not made in an arbitrary fashion or for the sake of convenience; far otherwise, for it is held that in all cases which can possibly fall under the designation of phthisis, or, in other words, in all cases which are characterised by the progressive destruction or excavation of a non-malignant pulmonary consolidation, the bacillus tuberculosis indubitably exists. Let it, they say, be conclusively shown that such a destructive lesion can arise and proceed which at no period throughout its whole course is associated with the tuberculous organism, and then the question of the identity of phthisis and pulmonary tuberculosis may be reconsidered. Now this demand, even granting it can be fulfilled, is excessive. For in the case of pulmonary inflammations or consolidations which at a certain period of their course happen to become contaminated with the tubercular bacillus, it is evident that the bacillus, not having originated the disease, can hardly lay claim to an undivided sway. Such, for example, are cases of fibroid phthisis in which the tuberculosis occurs as a late accident of the disease; and if such tuberculosis should be limited, undergo fibroid change, and not very materially alter the regular progress of the signs and symptoms of the malady, the scientific narrowness involved in denominating the affection a tuberculosis of the lungs becomes palpably manifest.

In order to assist in the solution of this problem of phthisis and tuberculosis it becomes almost imperative at the present time that any case which possesses unusual features, such as the absence of bacilli from the sputum with signs of much mischief in the chest, should be carefully noted. In particular post-mortem examination of such cases should be thoroughly carried out, for the failure to find bacilli in the sputum during life is by no means conclusive as to their absence from the lungs. With this end in view I submit a short account of a case which made a deep impression on all who had the opportunity of seeing it at the post-mortem examination, and the features of which during life have been pretty accurately obtained. It is that of a young man aged thirty, by occupation a tinsmith, who was received into the infirmary in June, 1886. He looked pretty well, though somewhat emaciated, and his family history revealed no phthisical taint. He dated his illness from an attack of inflammation of the lungs ten years previously. Ever since, more or less cough had troubled him; this cough had become constant and attended with a yellowish spit, occasionally blood-streaked, for the last four years. Two months before his admission to the hospital he observed that the expectoration was acquiring a disagreeable odour. He complained of a pain in the chest to the right of the sternum, and his expectoration was profuse, muco-purulent and of a somewhat fetid odour. His respirations numbered 22. On inspection the right side of the chest was flattened and expanded but feebly. Palpation revealed general dulness over this lung, and the respiratory murmur is described as much deficient. The left lung was found to be practically normal; the other organs normal. The temperature hovered irregularly between 99° and 103°. This incomplete note is supplemented by the statement that the patient left the hospital after six weeks, greatly improved and with the expectoration in a much healthier condition. The patient again came under observation, this time in the Western Infirmary, after an interval of four months. He had much cough and dyspnœa and a yellowish expectoration of an offensive odour. The left lung had now become involved. Retraction, dulness and tubular breathing existed over the apex. Crepitations were heard in the supra- and sub-scapular regions. The respiratory murmur was impaired throughout and tubular breathing was likewise noted at the base. Dulness on per-

cussion and hollow breathing existed generally over the right lung, with crepitation at the base and vocal fremitus markedly increased, especially over the subclavian region. The patient was rather emaciated and nocturnal perspirations were profuse. A hectic flush appeared at times, and there was clubbing of the fingers. In short, the classical signs and symptoms of advanced phthisis pulmonalis were exhibited in a marked degree. But the patient improved, left the hospital after a few weeks' duration, and was not heard of for *four years*, when he returned to die a few days after admission. At this time the sputum was profuse and mucopurulent, but not fetid, and careful examination completely failed to discover in it any tubercle bacilli. At the post-mortem examination conducted by Dr. Coats, the right lung had to be dissected from the chest wall. It was the seat of several cavities. One was huge, extending from apex to base, and was seven inches in length and four in breadth. It was lined throughout by a perfectly smooth, fibrous membrane, considerably sacculated, and reflected at several points over bridges which stretched across the cavity. This large cavity communicated with a smaller one in the posterior aspect above, and an isolated cavity, two inches and a half in diameter, existed posteriorly below. All these cavities were quite empty, quiescent and lined by smooth, fibrous membranes. Hardly any lung tissue was left and no trace of active disease could anywhere be seen. This specimen is preserved in the Infirmary museum. The left lung was united to the chest wall by adhesions of cartilaginous consistence, especially at the apex. The upper lobe was somewhat shrunken and consisted of dense fibrous tissue of a dark grey colour. In the midst of this tissue were frequent collections of a pultaceous and calcareous matter; the rest of the organ was the seat of apparently recent lobular condensations and was otherwise œdematous. The other organs were healthy. Careful microscopical examination of this lung made both by Dr. Coats and myself revealed entire absence of tuberculosis. The indurated upper lobe contained condensed and partially cretified pus, while the lobular condensations were composed of a dense fibrinous exudation which filled both bronchi and alveoli.

Without dwelling at length on this remarkable case, will it not at once be conceded that it affords a most striking illustration of the degree to which destruction of the lungs may proceed without the demonstrable presence of tuberculosis? What objections or arguments can be adduced against its non-tuberculous nature? Suppose it be said that tuberculosis may have existed at some time, but had become quiescent or disappeared. Now if the tuberculosis had become quiescent, so would the symptoms of the disease, but the patient died of a disease other than tuberculosis. Again, seeing that the right lung was the seat of disease to begin with, how is it that no remains of old tuberculous disease was discovered in it? By no subterfuge can the conclusion be evaded that this was a case of non-tuberculous phthisis. And we are therefore warranted in believing that there are two varieties of fibroid phthisis—one which is either complicated with or originated by a tuberculosis, and another which is not associated with that neoplasm, or, in the words of the distinguished physician who has done so much to elucidate this subject, there is a bacillary and a non-bacillary fibroid phthisis.[1]

I here wish to draw attention to a confusion of terms which has centred round this lesion. Some regard fibroid phthisis as synonymous with Corrigan's cirrhosis, interstitial pneumonia, chronic pneumonia &c. The late Dr. Wilson Fox described under the title of "chronic pneumonia" a large number of chronic inflammatory lesions differing both in their origin and progress. Some originated in acute pneumonia, others in broncho-pneumonia, others in pleurisy and probably a few in bronchiectasis. A simple progressive interstitial pneumonia akin to cirrhosis of the liver or kidney he could find no evidence of, while the existence of an idiopathic fibroid change in the alveolar walls independently of inflammatory action (the "fibroid degeneration" of Sutton) he denied. This chronic pneumonia, according to Fox, "is commonly unilateral; it is frequently associated with dilatation of the bronchi and it tends either through ulcerations proceeding from these or from secondary inflammation of the indurated tissue to give rise to cavities in or gangrene of the lung."[2] As has previously been mentioned, probably many of Fox's cases would now be regarded as tuberculous, but some assuredly are not, and I would therefore venture to suggest that the terms "chronic pneumonia" and "interstitial pneumonia" should receive a more limited meaning than they have hitherto possessed. If the term "chronic pneumonia" were employed as signifying a simple fibroid consolidation in the lung, while fibroid phthisis were regarded as signifying the accession and course of destructive changes in such a lung, this leading to cavities, a gain would be made in the matter of nomenclature. Moreover, it is scientifically inaccurate as well as an injustice to the patient to style a simple fibroid consolidation "phthisis."

A summary of the various modes of origin of such conditions as ultimately assume the characters of non-tuberculous or simple fibroid phthisis may not be amiss here. Regarding chronic pneumonia as a generic term, and to represent the prephthisical stage of the disease, it may be held to embrace cases which originate more or less definitely and acutely and likewise a group of cases which are more or less chronic from the first. Of the latter class the existence of a primary cirrhosis of the lung, resembling renal cirrhosis, is held by many authorities, and it is certainly the characteristic lesion of pneumoconiosis. More commonly, however, chronic bronchitis, with peri-bronchitis leading to localised lobular indurations and bronchiectasis, form the starting point of the disease. In other cases bronchiectasis appears early, and the stagnant secretions cause circumscribed inflammation round the dilatations, ending in induration. More or less pleurisy is frequently associated with these lesions which form the basis of the most classical type of fibroid phthisis. Of the other or acute class of cases pleurisy and acute broncho-pneumonia are most frequent. Some doubt whether a simple pleurisy can originate an induration of the lung, but the evidence is in favour of such a sequence, for inflammatory changes in the lung are frequently traceable to progressive ingrowth from the pleura. In the last place, and least frequent, is acute pneumonia. Evidence has lately been accumulating in favour of its occasional, though very rare, issue in induration. Some confusion has arisen here because two different forms of induration have been observed to occur after this affection. In one of these the lung appears much shrunken, either in whole or in part, bronchiectatic and altogether resembling Corrigan's cirrhosis. Now in such cases it will invariably be found that the lesion is due to pleurisy which has complicated and outlived the pneumonia. The other or genuine pneumonic induration has individual features of its own totally different from those presented by any other chronic affection of the lungs, and hence I claim that it is justly entitled to a separate designation. Dr. Coupland, in this country, was the first to put on record the microscopical appearances in this affection, which consist in a fibroid transformation of the pneumonic exudation. Working further at this subject led me to suggest the name "fibroid pneumonia" for it. It shows but slight bronchiectasis, but may issue in fibroid phthisis through intercurrent inflammation or necrosis of the indurated tissue.

Glasgow.

[1] Lecture on Fibroid Phthisis, by Sir Andrew Clark, THE LANCET, July 2nd, 1892.

[2] Diseases of the Lungs and Pleura. Edited by Dr. Coupland, p. 412.

THE TREATMENT OF THE PERITONEUM IN ABDOMINAL SURGERY.[1]

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THE attainment of success in abdominal work, as in any other department of surgery, must naturally in great measure depend upon the training and special experience of the individual operator. But apart from these general factors the observance of certain important details in relation to the methods of treatment employed undoubtedly tends to influence the proportion of successful results obtained in any given instance. Surgical procedures implicating the peritoneum may in some degree be considered as regulated by different laws from those which guide the surgeon in dealing with other serous cavities. This fact is dependent not alone upon the large extent of the peritoneal surfaces, with their numerous folds and recesses, but, further, upon the peculiar vital properties which characterise this membrane as regards both its special structure and its intimate relation to the main excretory organs of the system, through the ready channel afforded by the subjacent lymph and bloodvessels.

[1] A paper read at the Medical Society of London on Oct. 23rd, 1892.

In evidence of the enormous powers of secretion and excretion possessed by the peritoneum, so long as its epithelial surface is comparatively intact, one has but to consider the readiness with which effusion of so-called ascitic fluid takes place as a result of interference with the return of blood through the portal system; and, again, the equally wonderful rapidity with which such effusion may disappear upon the re-establishment of the normal balance of circulation within the vessels underlying the serous membrane; whether as the result of removal of the original hepatic obstruction, or as a consequence of relief to the vascular engorgement obtained by derivative action through the renal and intestinal emunctories.

With these facts in view, and therefrom considering the peritoneum in the light of a huge lymph sac, one cannot, I think, too highly estimate the practically unlimited powers for good as for evil which it possesses in relation to operative measures involving its cavity. From such a standpoint as this it seems to me that success in abdominal work, apart from the general factors already alluded to, may be said to largely depend upon the attainment by the surgeon of three main objects which should be kept constantly in view when dealing with the peritoneal cavity.

First of these three I will place "avoidance of the introduction into the serous cavity of any septic or potentially septic material," comprising under this latter denomination any substance or fluid which may, under favouring circumstances, afford a protective nidus or medium for the subsequent development of organisms within the peritoneal sac. It may, I believe, be definitely asserted that the surest and most effective protection against the risk of such introduction of mischief from without during abdominal operations lies in the rigid routine employment of antiseptic—preferably carbolised—lotions for sponges, ligatures and instruments, as well as for the hands of the operator, his assistant and nurses. While expressing this opinion, the truth of which is to my mind absolutely certain, I am fully prepared to admit the possibility of the attainment in skilful hands of good results without the use of any antiseptics whatever during intra-peritoneal operations, providing always that scrupulous cleanliness of procedure be observed, and that the recognised methods of flushing and subsequent drainage of the abdominal cavity be followed in suitable instances. But, at the same time, I have no hesitation whatever in stating that a surgeon who thus trusts to the use of plain water as a substitute for carbolised lotions unwisely neglects one of the surest safeguards against septicæmia, and that, although he may for a while secure good results, his work in the long run must inevitably suffer from such omission. The explanation of this fact is not far to seek. It is not possible, even with the strictest use of antiseptic methods, to entirely banish all risk of septicæmia from abdominal work, since one is constantly exposed to meeting with cases where the poison in an active or potentially active state is present within the peritoneal cavity before operation—e.g., ovarian cysts with septic contents as a result of previous tapping, putrid gestation sacs, tubes distended with puriform fluid, pelvic abscesses &c. Under such conditions a free use of antiseptics with the object of minimising the risks of subsequent mischief by weakening the already existent germs of infection, and thus rendering them an easier prey to the destructive power of the leucocytes, offers indisputable advantages over those afforded by the employment of plain water for mere cleansing purposes. A further advantage possessed by a Listerian operator—one more readily appreciable, perhaps, in hospital than in private practice—is the degree of protection afforded by the routine use of antiseptics against the recurrence of disaster after a death from septicæmia. Anyone who will take the trouble to examine the record contained in Sir Spencer Wells's work on "Ovarian and Uterine Tumours" (London, 1882) of consecutive ovariotomies performed previously to his adoption of the antiseptic method in 1879, cannot fail to observe that a death from septicæmia, occasionally succeeding to a series of as many as twenty-five recoveries, was almost invariably followed by a more or less interrupted succession of fatalities attributed to septic causes. Such a noteworthy fact—accountable for only by the transmission of infection from one case to another, whether through sponges, silk, instruments or by the hands of the operator or nurses—constitutes, to my mind, one of the strongest arguments in favour of antiseptics in abdominal work, since we know that by their use we can surely lessen, if we cannot altogether avoid, the risk of thus unwittingly conveying infection from one patient to another.

Turning now to the *second* of the objects to be kept in view by the abdominal surgeon, I would define it as "avoidance of the infliction of any unnecessary injury to the peritoneum whereby its vital properties may be impaired." It was long ago pointed out by Sir Joseph Lister that any suspension of vital activity in a tissue as the result of injury leads to paralysis of its special functions and to consequent impairment of its ability to resist the entrance of parasitic organisms. This observation is one of very grave moment when considered in relation to its bearing upon so delicate a structure as that which characterises the serous membrane lining the abdominal cavity, and in confirmation of its importance we have the statement of so high an authority on this subject as Professor Watson Cheyne, to the effect that "one of the conditions favouring the development of peritonitis as a consequence of the introduction of cocci into the peritoneal cavity is an abnormal state of the serous membrane whereby its absorptive power has been diminished—as, for example, by the action of any substance which weakens or kills the serous tissue, and thus provides a suitable soil for the penetration of the cocci."[2]

Now depression of vitality may be either general or local; and any method of treatment tending to induce it in either direction should, in my opinion, be sedulously avoided. This brings me to the question of the employment of the carbolised spray in abdominal work. I have myself entirely given up the spray since the end of 1888; and, so far as I know, its use has now been abandoned by the leading abdominal surgeons in this country, with the sole exception of Mr. Thornton, who, I believe, still employs it in peritoneal operations. Were it not for this latter fact I should not consider it necessary to further allude to this subject of the spray, but under the circumstances I deem it well to briefly note my own chief objections to its use. In the first place, we have no proof whatever that the carbolised spray can safeguard us against the introduction of septic mischief into the open abdominal cavity otherwise than by maintaining a form of constant antiseptic irrigation for moistening the exposed surface of the patient's abdominal wall, as well as the hands of the operator, his assistant and nurses. While fully admitting its usefulness in this respect, I am convinced that the object in view can equally well be attained by the exercise of ordinary care on the part of a Listerian operator in the way of sponging and frequent ablutions; and that he may thus secure all the advantages derivable from the use of carbolic acid without exposing his patient to the risks entailed by the chilling properties of the spray. These latter constitute my own chief objection to its employment. Anyone who has stood for an hour or more assisting with bared arms in the performance of an abdominal section under a steam spray can form for himself a tolerably accurate estimate of its powers in this direction; and thus in some measure conceive the extent of its depressing influence upon the vitality of the patient, a portion of whose abdominal wall is of necessity exposed to the cold moist blast. Such exposure during prolonged operations, especially in wintry weather, undoubtedly entails serious risk of death from shock in the case of feeble, elderly patients; while, short of this, it not unfrequently interferes gravely with the progress of convalescence by originating troublesome chest complications. In addition, however, to the depressing influence of the steam spray upon the general vitality of the patient, one must further take into account its direct action upon the peritoneum itself during the removal of large solid tumours necessitating a lengthy abdominal incision, or in cases of ovarian or other cysts complicated by the presence of extensive adhesions. Under such circumstances I am convinced that prolonged exposure to the chilling and irritating influence of the carbolised spray—while necessarily increasing the general depression—undoubtedly further tends to temporarily impair the vitality of the serous membrane itself over areas of greater or less extent; and, by thus lessening its powers of absorption, to induce the abnormal condition above referred to as favouring the penetration of cocci and the consequent development of peritonitis. A still more definite, but commonly unrecognised, source of injury to the peritoneum, leading to more or less extensive impairment of its vital functions, arises from the performance of what was formerly known as the "toilette du péritoine"—a procedure commonly involving assiduous and prolonged sponging of the abdominal cavity in cases of extensively adherent or ruptured cysts.

In my early operating days I naturally followed in this

[2] Brit. Med. Jour., vol. i. 1888, p. 524

regard the example set me by my two senior colleagues at the Samaritan Hospital, both of whom were then extremely careful in thus cleansing the peritoneal cavity at the conclusion of an abdominal operation. Such treatment, in complicated cases, was usually followed within forty-eight hours by a smart rise of temperature to 102° or over, frequently necessitating the use of an ice cap for its reduction. When I began in 1882 to assist Sir Spencer Wells, who then operated with full antiseptic precautions in every respect similar to those employed in the Samaritan Hospital, I soon became impressed by the fact that complicated cases of ovariotomy, where no attempt was made to sponge away the mixture of blood and other fluids remaining in the pelvic cavity at the conclusion of a troublesome operation, not unfrequently recovered with but very slight disturbance of either temperature or pulse, although no drainage-tube was used. Such results following treatment so opposed to the routine practice in the hospital at that time puzzled me somewhat, until I formed the conclusion that avoidance of unnecessary irritation of the serous membrane might have something to do with them; and, as time went on, my views in this direction were materially strengthened by watching the results obtained in cases where the abdomen was washed out with warm water instead of being cleansed by sponging. I have now myself employed this treatment of "flushing" with increasing frequency for over four years past, and am constantly more and more impressed by its value—as a ready and efficient means of cleansing the peritoneal cavity with the minimum infliction of damage to the delicate epithelial surface of the serous membrane—a fact which from my point of view constitutes one of its greatest advantages. As a firm believer in the importance of asepticism I need hardly add that I consider it advisable always to employ for this purpose water which has been previously sterilised by boiling, as the surest means of avoiding the introduction of possible mischief into the peritoneal cavity.

Passing on now to a brief consideration of the *third* of the three objects to be aimed at by the abdominal surgeon, I define it as the "promotion of the subsequent removal by natural or by artificial means of any fluids remaining in the pelvic cavity at the conclusion of the operation." By the term "natural means" I would imply the early re-establishment and maintenance of the renal and intestinal eliminatory functions which play so large a part in promoting the absorption and subsequent excretion of peritoneal effusions. Without dwelling on this subject I will here merely refer to what I believe to be the extreme inadvisability of the routine administration of opium after abdominal operations, owing to the restraining influence thereby exercised upon these functions; while further noting the value of repeated small doses of salines administered not with a view to relieving any tendency to obstructive bowel difficulty, but merely as promoting renal and intestinal excretion. By the artificial or mechanical means above mentioned I of course allude to drainage of the pelvic cavity as best effected by the ordinary glass tube whence the accumulated fluid is withdrawn at stated intervals. An objection formerly raised against this method of drainage was based on the statement that it was liable to be followed by a ventral hernia at the seat of insertion of the tube. Such a mishap has fortunately been extremely rare in my own experience, and I regard its occurrence as indicative of too prolonged retention of the tube. In my opinion all the good derivable from drainage of the peritoneal cavity proper is commonly attained within the first twenty-four to forty-eight hours after operation, and any further prolongation of the process is but rarely advisable. My own invariable rule is to remove the tube whenever the entire amount of fluid accumulated during the previous twelve hours is found not to exceed two to four drachms, and this quite irrespective of whether the serum then withdrawn be bloodstained or not.

In support of the views here expressed I will now very briefly summarise the results obtained in my practice from December, 1888, when I abandoned the use of the spray, to the end of July, 1892. During this period of about three years and a half the total of my abdominal operations amounted to 201; but in eighteen of these, chiefly cases of pelvic abscess, the serous cavity proper was not invaded,[3] and I shall consequently confine my remarks to the remaining 183 operations, all of which implicated the peritoneum. Of this number, forty-two were undertaken for disease either unconnected with the pelvic organs or, when so connected, of such a nature as not to admit of complete extirpation. Thirty-three of these patients recovered, and the remaining nine died from causes shown in the accompanying table.

TABLE I.—*Peritoneal Operations.*

No.	Nature of disease.	Cause of death.
1.	Double intra-peritoneal abscess (of septic origin).	Shock, within six hours.
2.	Cancer of both ovaries (partial operation).	Shock, within four hours.
3.	Advanced tubercular disease of peritoneum.	Exhaustion, on twelfth day, from persistent diarrhœa.
4.	General abdominal cancer.	Exhaustion, on eighth day.
5.	Pelvic cancer.	Exhaustion, on fourth day.
6.	Intra-peritoneal abscess (? of tubal origin).	Exhaustion, on seventh day.
7.	Retro-peritoneal sarcoma.	Exhaustion, on third day.
8.	Cholecystotomy.	Perforation of intestine, on twenty-eighth day.
9.	Hydatid disease of liver.	Cerebral disease, on eighth day (? hydatid).

The remaining 141 peritoneal operations were performed for disease originating in the uterus or its appendages in the following proportions and with the results here shown—viz., 137 recoveries and 4 deaths.

TABLE II.—*Peritoneal Operations.*

Eighty-four cases of ovarian tumour.	One death from pneumonia on thirteenth day.
Fifteen cases of chronic inflammatory disease of one or both uterine appendages.	One death from intestinal obstruction on eighth day.
Five cases of ruptured tubal pregnancy with intra-peritoneal hæmorrhage	One death from exhaustion within five hours.
Thirty cases of supra-vaginal hysterectomy for fibro-myoma.	One death from shock.
Seven cases of removal of the uterine appendages for fibro-myoma.	No death.

This series of 141 operations performed on the lines indicated in my paper, with a mortality of under 3 per cent., may, I think, be taken as affording some evidence of the correctness of the views advocated with regard to the treatment of the peritoneum in abdominal work; and, in conclusion, I would here venture to express the hope that the record of my experience in this direction may tend to promote a fuller recognition of the enormous powers for good as for evil possessed by the serous membrane in relation to surgical procedures involving its cavity.

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[3] The group of eighteen operations above referred to included seventeen recoveries and but one death, which resulted from exhaustion due to diffused pelvic suppuration of some two years standing previous to surgical interference.

ALVEOLAR ABSCESS; PYÆMIA; EXCISION OF THROMBOSED VEINS; DEATH.

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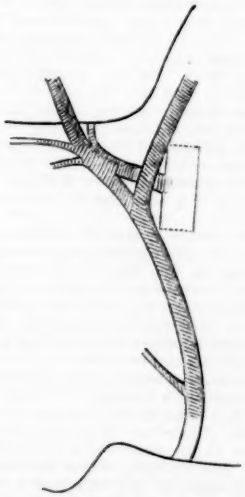
ASSISTANT SURGEON TO GUY'S HOSPITAL AND THE HOSPITAL FOR SICK CHILDREN.

H. R——, aged four years, was admitted into Guy's Hospital on Aug. 18th, 1892. He was suffering from a swelling over the left half of the lower jaw, which commenced with toothache about a week before. Five days previously an abscess burst into the mouth, and since that time the swelling had diffused itself more extensively. His temperature on admission was 105·4°. There was an alveolar abscess about a carious second molar tooth. This was removed and the abscess cavity scraped and thoroughly cleaned out under an anæsthetic. The boy became jaundiced and suffered from recurring rigors on the 19th, 20th, 21st and 22nd. On the 22nd I saw the child for the first time and decided to make an attempt to stay the progress of the condition by excising any thrombosed veins that might exist and by clearing out the inflamed bone and other tissues. At this period the patient was deeply jaundiced and the liver much enlarged; he had, however, no apparent renal complication, though there was strong presumptive evidence of patches of pulmonary mischief. The skin was turned back from the anterior triangle and sterno-mastoid when the external jugular vein was exposed, and was found to contain a purulent material to within half an inch of its lower end.

There the clot was black, and below this point, at its junction with the subclavian, the external jugular vein was tied and divided. The walls of the vein, with the immediately adjacent tissues, were inflamed and thickened. The external jugular vein was then followed upwards into the parotid and forwards to its junction with the facial vein. The latter was dissected out and was found to be filled with a firm pale clot. The branches of the facial vein, with the exception of the distal portion of the submental, were filled with clot of the same character. The common facial vein was also thrombosed, the clot extending for a slight distance into the lumen of the internal jugular vein, which was exposed for a distance of half an inch above and below the point of entry of the common facial vein, and after it had been ligatured at these two points the intermediate portion was excised. Having removed all the thrombosed veins thoroughly on their proximal side their distal distribution was treated in as effectual a manner as possible, though it was obvious that this portion of the operation was not as perfect as the rest. The abscess cavity and bone were then cleaned thoroughly and plugged with iodoform. During the course of the operation many inflamed lymphatic glands were removed. The patient seemed better on the day following the operation. The jaundice disappeared almost if not entirely by Aug. 25th. The next day



This diagram illustrates the extent of the thromboais and the several veins which were removed at the operation. The transverse striation represents the thrombosed area of vessel.

it was found that the wound in the neck, whose edges had apparently healed and were devoid of any redness, contained a quantity of yellowish pultaceous material. This was all carefully removed and the wound was thoroughly washed out and packed with iodoform and gauze. He had a gradual rise of temperature to 105·4° on the 23rd, but after that it remained at between 101° and 103° till his death. He had no rigor. The child gradually got worse and died at twelve o'clock on the night of the 26th. At the post-mortem examination it was found that the thrombosed veins had been removed very effectually as far as their proximal distribution was concerned, there being no evidence whatever of thrombosis. There were, however, a number of abscesses in the lungs and liver. These had without doubt been produced by septic emboli at a period antecedent to the operation, which was obviously performed too late. Though the result in this case was unsatisfactory as far as the life of the patient was concerned, it was, on the other hand, most satisfactory and instructive as showing that the method of excising septically thrombosed veins is as effectual in staying a pyæmic process originating in the lower jaw while it is as yet local and uncomplicated by secondary abscesses as it is a more definite and localised thrombosis of the lateral sinus due to disease of the middle ear.

St. Thomas's-street S.E

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se compare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Procemium.

WESTMINSTER HOSPITAL.

SUPRA-PUBIC CYSTOTOMY FOR CALCULUS.

(Under the care of Mr. R. DAVY.)

THE following account of a method of performing the supra-pubic operation for the removal of a stone from the bladder of the male has one or two points worthy of attention. The performance of the operation without the use of the rectal bag, and without previous distension of the bladder by injection, appears to have been rendered easy and safe by means of the sound described by Mr. Davy. There is no doubt that with the use of this sound the operation was done in less time than is usually required, and therefore was of less severity—a fact of great importance, especially in men of advanced age, for the introduction and filling of the rectal bag and the injection of fluid into the bladder cannot be hurriedly performed without considerable risk. In this case the condition of the urinary passage was such as to have rendered the manipulation of a lithotrite or its introduction difficult, and the danger of bruising the parts, with subsequent swelling and possibly retention, of serious moment. For the notes we are indebted to Mr. H. De Renzi, house surgeon, and Mr. Forsayeth, dresser.

J. R——, aged sixty-three, by occupation a carpenter, was admitted into the Westminster Hospital on Aug. 2nd, 1892, and discharged on Aug. 30th. Twenty years ago he spent six months in Derbyshire, but usually has lived in London. In March last he was knocked down by a tram-horse; the same evening he experienced pain in passing his urine, and a week afterwards he had hæmaturia, sometimes in clots, at other times intimately mixed with the urine. Forty years ago he had gonorrhœa, and since his fall he had suffered from a difficulty in micturition, necessitating the constant use of a catheter. Pain at the bladder and scalding around the anus have been increasing of late. On Aug. 6th, on sounding, a stone of medium size was detected. The abdominal wall was normal and the patient fairly nourished, there being no excess of fat in the subcutaneous tissue. The urine was strongly alkaline, sp. gr. 1015; half albumen was found, and blood, pus and mucus were present. On the 9th supra-pubic cystotomy was performed by Mr. R. Davy. Neither the bladder nor rectum was distended. A conical probe-pointed sound was used, with a groove on its concavity and a hole at its tip. A medium-sized stone was extracted, measuring two inches by an inch and a quarter, weighing seventy-five grains, and composed throughout of soft phosphatic material. The mucous membrane of the bladder was inflamed and sacculated, the No. 4 sound being sufficient to bring the bladder wall well forward after the incision of the abdominal parietes. A silver drainage-tube was passed into the bladder and left in. It appeared that the obstruction to the outflow of urine was due to thickening and hypertrophy of the prostate and spasm of the muscles of the urethra. On the 11th the patient passed urine naturally and the drainage-tube came away. On the 19th he was well, and on the 30th he was discharged cured.

Remarks by Mr. DAVY.—The supra-pubic operation, in my opinion, was the best suited for this man, and for these reasons: (1) Crushing was out of the question on account of the difficulty in manipulating or even passing instruments in the urethra of the patient; (2) the high operation, on anatomical grounds, wounds less important structures than those injured in median or lateral operations. In this case neither bladder nor rectum was artificially distended. I wished to operate on the bladder as I found it; as a rule, I have operated with the bladder partly full of water. There is neither difficulty nor danger in operating without distension if the surgeon bears in mind that the bladder is situated for this intent post-symphysially. I can recall more than

one case where the peritoneum has been injured, although fluid distension had been practised, and students not infrequently puncture the peritoneum on the dead body in performing supra-pubic cystotomy, unless the teacher points out this danger and its remedy with emphasis. Mr. George Pollock, who was present at the operation, has introduced a very pronounced curve at the end of the sound, which allows the tip to hook round the symphysis and elevate the bladder wall at the same time. I can testify to the facility given by his instrument in the performance of the operation, and it seems to be preferable to the sonde à dard advocated by Frère Jacques of Orleans. It is satisfactory to note that the urethral obstruction has benefited by the removal of spasm caused by the stone in the bladder. The patient passes his urine now in a normal stream.

SOUTH DEVON AND EAST CORNWALL HOSPITAL, PLYMOUTH.

COCCYDYNIA; EXCISION OF COCCYX.

(Under the care of Mr. LUCY.)

THERE are many conditions for which it may be necessary to excise the coccyx, but we rarely meet with any of them in practice. The patients usually give a history of injury to the part, which on examination is found to have sustained fracture or displacement, or the injury may have led to a chronic inflammation of the bone or joint or to necrosis of the bone. The formation of a tumour or a congenital elongation of the bone may necessitate excision. There is also a group—of which the following is an example—in which after removal no abnormal change in the bone is found. It is difficult to diagnose these cases of coccydynia from hysterical or reflex cases. The condition is somewhat rare in men. Descriptions of the operation have been published in THE LANCET from time to time. We may instance cases under the care of Mr. Whitehead[1] and Mr. Odell,[2] and an interesting letter by Dr. Nott.[3]

J. M——, aged sixty-three, single, cook, was admitted on Feb. 4th, 1892, complaining of great pain in the lower part of the back when sitting down, which had been present for over a year. A few years ago she slid off a table and hurt "the bottom of her spine" on a tiled floor. She had no pain on walking or on defecation. There was a small swelling the size of a marble to the right of the tip of the coccyx and presenting a small dimple on the surface. The coccyx was freely movable forwards at the sacro-coccygeal joint, the movement causing the patient intense pain. She also had a slight anal fissure and an intero-external hæmorrhoid. So, thinking that the neuralgic symptoms might be due to the latter, she was given chloroform on Feb. 12th, and the sphincter was stretched and the hæmorrhoid removed by crushing. She quickly got well from this operation, but the severe pain on sitting persisted; therefore, on Feb. 26th she was again anæsthetised. A longitudinal incision was made over the coccyx down to the bone, the periosteum was divided and separated by a raspatory and the coccyx removed. At its tip there was a small dermoid cyst containing sebaceous material, which was dissected out. Hæmorrhage was pretty brisk from several small arteries in front of the coccyx. The wound healed by granulation. She got up on March 30th, the wound being quite sound, walked on April 9th, and left the hospital on April 26th, being able to sit comfortably without any pain at all. She was last seen on May 26th, three months after the operation, the wound was soundly healed, and she was back at her work, was quite free from pain on sitting down, and was putting on flesh.

[1] THE LANCET, vol. ii. 1886. p. 112. [2] THE LANCET, vol. i. 1887, p. 1088. [3] THE LANCET, Nov. 5th, 1870, p. 654.

MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.—The next quarterly meeting will be held at the Royal College of Physicians, Edinburgh, on Thursday, the 10th inst., when a paper will be read by Dr. G. M. Robertson on the "Treatment of Acute Mania," and Dr. Turnbull will open a discussion on "Asylum Dietaries." The next examination for the Certificate in Psychological Medicine will be held in December and for the Nursing Examination in May.

Medical Societies.

CLINICAL SOCIETY OF LONDON.

Macrocheilia treated by Electrolysis.—Subcutaneous Suture of Patella.—Transverse Fracture of Patella.—Raynaud's Disease.—Amputation of Arm for Lymphatic Œdema in cases of Breast Cancer.—Congenital Deficiency of a portion of Chest-wall.—Sinus in Loin connected with Posterior Mediastinal Abscess.—Sarcoma of Skin.—Complete Erasion of Ankle-joint.

A "CLINICAL" meeting of this Society took place on Oct. 28th: the President, Sir Dyce Duckworth, in the chair.

Mr. ARBUTHNOT LANE showed a man, aged twenty-eight, who was employed at the General Post Office and who three years and a half ago struck his upper lip; this was followed by very great swelling, and two months later the lower lip also became swollen. The swelling was hard and brawny, and after a short time the cheeks became hypertrophied in the same way. Having refused to yield to other treatment, electrolysis was employed on several occasions, and the lips had returned to their normal state, except that the lower lip was still a little larger than it should be.

Mr. BARKER showed a man, aged twenty-five, a porter, on whom he had performed subcutaneous suture of the patella. The wire still remained round the bone, which was united by a strong fibrous band. He was on a splint for three weeks after the operation and left the hospital at the end of a month. It was done in March, 1891, the fracture being transverse and the wire for the suture being one-sixteenth of an inch thick. The patient had been doing very hard work since, and the movements were very free. Since then he had operated on a second case, and he had allowed him up without a splint at the end of a week, and he was able to walk freely in six weeks.

Mr. PAGE also showed a case of transverse fracture of the patella in a patient aged thirty-three, in which subcutaneous suture, according to Mr. Barker's method, was done on May 18th, 1892. The man was a coalheaver by trade, and the result was good, as he thought that the union was bony. He had since treated in a similar manner a case of compound fracture of the patella, which had also done well; but in both cases he had used silk and not wire.

Dr. F. LITTLE showed a girl employed at a florist's, who was the subject of Raynaud's disease. When aged nineteen both the hands and feet began to feel cold, but this was unaccompanied by pain. Ulceration then commenced around the nails of all the fingers except the little fingers, and since then shortening and clubbing of the terminal phalanges had occurred. The nails of the toes had not been affected. There was nothing in the family history to throw light on the case. The body temperature was normal but the surface temperature of the hands was 65° F. There had been no hæmaturia or hæmoglobinuria. The treatment consisted in the exhibition of nux vomica and steel, together with the local employment of galvanism.

Mr. BLAND SUTTON showed two cases of amputation of the arm for lymphatic œdema in cases of cancer of the breast. The first was a woman aged forty-three, who, two years and a half ago, had the right breast removed for cancer. Six months later some knots began to form in the skin of the scar, and later the whole of the neighbouring parts were invaded *en cuirasse*. The arm then became much swollen and œdematous, being three times its normal size, extremely heavy, and it had already induced a moderate degree of lateral curvature. The limb was removed at the shoulder-joint and the patient made a good recovery, being able to get about without pain. The second case was that of a patient aged sixty-four, who, four years ago, underwent the operation of removal of the right breast for scirrhus. Eighteen months ago recurrence occurred, and a large mass formed in the axilla. The arm presented a more marked degree of lymphatic œdema than did that of the last patient; she was obliged to carry the limb in a sling, and it was exceedingly painful. In this case he followed Mr. Treves's plan, dividing the clavicle and amputating the humerus and scapula. The limb, after removal and after much of the fluid had drained away, still weighed fourteen pounds. The wound healed in three weeks and the patient left the hospital much relieved.

Dr. ABERCROMBIE showed a child with a congenital defi-

ciency of a part of the anterior chest-wall. The infant was two months old; there was absence of the third and fourth costal cartillages on the left side and defect of the left second rib. The gap left was protected by nothing but skin; there was also some deformity of the fingers of the left hand. He likewise showed the chest-wall of a child who had been under his care ten years ago with a similar deformity.

Dr. SIDNEY PHILLIPS showed a museum preparation of a somewhat similar case, which, when alive, he had shown at the Society. There was a deficiency of the xiphoid cartilage, and the diaphragm failed to gain an attachment anteriorly, so that the heart's apex lay in the abdomen.

Mr. SPENCER showed a girl who had a sinus in the left loin connected with an abscess in the posterior mediastinum. The collection of pus in the loin formed painlessly, and he opened it and slit up the sinus, finding a narrow channel running in front of the twelfth rib. He cut through the neck of this rib and found that the sinus ran up beside the spine. The examination of it involved great care on account of the proximity of the pleura. The discharge was very profuse and there was a fear of amyloid disease. He contemplated the desirability of extending the search further up by cutting through the necks of the ribs.

Dr. BRISTOWE made a communication on a case of sarcoma of the skin which resembled granuloma fungoides. He had unfortunately mislaid his notes, and therefore gave a *résumé* of the case from memory. The patient was aged about twenty-two and had been ill for several months before his admission into St. Thomas's Hospital. He was then emaciated and hectic, and half a square foot of his right axilla, chest-wall and neck were involved in the disease, which progressed rapidly. The skin was covered with projecting nodules which were raised from a quarter to half an inch above the cutaneous surface. They had an appearance very much like erythema nodosum and there were depressions from ulceration. A few of the nodules seemed to die away. On inspecting the ulcers a certain amount of new growth was seen upon their floors. It struck him as being more rapid and more ulcerative than granuloma fungoides. Some of those who saw it considered it to be a case of tuberculosis of the skin, though it was not like lupus. The patient died, and Mr. Shattock pronounced the growths to be sarcomata. But it was a curious point that the lungs were studded with minute tubercles and that the patient had hæmoptysis before his death.—Dr. HADDEN inquired if the lung-growths might not be miliary sarcomata.—Dr. RADCLIFFE CROCKER said that there were two varieties of granuloma fungoides; one in which chronic dermatitis was the first thing, and this was followed by the development of growths, the duration of the case being slow. In the second variety the tumours were formed first, and the case was more rapidly fatal. The French classified these cases under the head of lympho-sarcomata. A case such as those of the second class had been brought by Mr. Swinford Edwards before the Pathological Society.—Dr. PRINGLE inquired as to the method of the spread of the growth at its margin. Sarcoma, in contradistinction to granuloma, usually spread by nodules at the margin; these were at first subcutaneous and only to be discovered by palpation.—Dr. BRISTOWE in reply said that the growths did spread by nodules at the margin: these were at first discrete and subcutaneous; some of them disappeared, while others enlarged and joined the main growth.

Mr. ARBUTHNOT LANE related two cases illustrating an operation of complete erasion of the ankle-joint, by which the articulation could be exposed most fully and every particle of its synovial membrane could be seen and removed if necessary. The operation was performed in this manner: A more or less horizontal incision was made from the anterior margin of the internal malleolus, outwards, across the front of the ankle-joint, backwards immediately below the external malleolus, and inwards above the heel to a point over the tendon of the flexor longus hallucis, everything being divided down to the bone. The only structures about the ankle-joint which were not cut through were the internal lateral ligament, the tendons of the tibialis posticus, flexor longus digitorum, and the flexor longus hallucis, the posterior tibial vessels, nerve and the superjacent connective tissue and skin. On adducting the foot any portion of the interior of the ankle-joint was fully exposed, and the narrow prolongation of synovial membrane which ran up between the tibia and fibula could be examined and dissected out by cutting through the inferior interosseous and the anterior inferior tibio-fibular ligaments. It was therefore apparent that the interior of no other joint in the body could be more fully exposed and cleared of its synovial membrane than could this one by means of the operative procedure suggested. Should the disease have extended to the subastragaloid articulation it was necessary to divide all the structures covering in this joint superiorily and externally together, with the interrosseus ligament connecting these bones, and in extensive disease of the astragalus this bone might be excised with advantage. Whether the cut surfaces of the several tendons were sutured together or not seemed to affect the subsequent utility of the foot little if at all. Some care was, however, required in putting the foot up in plaster bandages after the operation that the fibula did not drop back a little off its facet on the astragalus.—Mr. CLUTTON had performed this operation by another method. Seven years ago he did the first case with a good result, and since then he had done six others, only one of which had afterwards to be submitted to amputation. He made an incision on each side from below each malleolus anteriorly; through these cuts he introduced a sharp spoon and his finger and scraped out the joint; cartilage and bone were removed as well if necessary. He subsequently put the limb on a knee-rest and kept it up for one or two years. Mr. Lane's method was evidently good if there was a sequestrum to be removed from the astragalus. In his own cases there had been no trouble as regarded movement of the toes, nor had the bones become displaced.—Mr. GODLEE said that he made lateral incisions and chipped off the malleoli, and thus got a good view of the joint.—Mr. PAGE said that in order to do a thorough erasion it was necessary to get such a view that every part of the joint could be seen; yet he could not help thinking that the cut need not be so free as Mr. Lane had made it, the anterior incision alone from malleolus to malleolus being in his opinion sufficient.—Mr. SILCOCK said that two years ago a case was shown at that Society of erasion of the ankle-joint by an anterior incision, which relieved the patient of the disease and ended in perfect mobility of the joint. After anterior erasion he had seen sensation restored over the dorsum of the foot in a few days, even although the nerve had not been sutured.—Mr. GOULD thought that if the joint could have been satisfactorily dealt with without so extensive a division of tendons it would be better for the patient. He questioned Mr. Lane as to the precise results he had obtained in the cases he had related, more especially as to the mobility of the joint.—Mr. LANE, in reply, said that he had unfortunately lost all trace of the first case. When he last saw him the foot was a good one for walking on, though it was flat and he could not turn the toes up well; there was some mobility in the ankle-joint. The second case had a very good foot. As the child could not move the toes, he had since shortened the tendons. It should be remembered that the cases were so bad that a Syme's amputation was the only alternative, and as opposed to that the results were very good indeed.

MEDICAL SOCIETY OF LONDON.

Intra-thoracic Auscultation.—Surgical Treatment of Cysts of the Vulvo-vaginal or Cowper's Glands.

AN ordinary meeting of this Society was held on Oct. 31st, the President, Mr. Hutchinson, in the chair.

Dr. B. W. RICHARDSON read a paper on Intra-thoracic Auscultation: a New Departure in Physical Diagnosis, which we publish in another column.—The PRESIDENT, after congratulating the author on the excellence of his communication, referred to the possibilities of diagnosis opened up by this new method.—Dr. ROUTH recalled a paper he had read some years ago before the British Medical Association on vaginal auscultation as an aid to the diagnosis of pregnancy &c.—Dr. RICHARDSON, in the course of some remarks in reply, demonstrated the effects of tubes constructed of rubber, metal and cane, his preference being at present for the former.

Mr. ALBAN DORAN read some notes on the Surgical Treatment of Cysts of the Vulvo-vaginal or Cowper's Glands. He began by reading notes of a case in his own practice. The patient was forty-eight years of age, and came to him for relief on account of an unusually large swelling of the left labium, which had existed for several months and caused great trouble whenever she walked or sat down. It fluctuated freely and could be felt extending far into the ischio-rectal fossa. He thought it advisable to remove the entire cyst, the portion in the ischio-rectal fossa being carefully dissected away. Four arteries were divided and required ligature.

The cavity left behind after removal of the cyst was washed out with hot water and packed with absorbent gauze. There was much oozing for five hours, then the wound was dressed again and drained. Within a few days healing was complete. Six months later there was no trace of any fistula. He believed that, as a rule, complete removal of these cysts was the most satisfactory practice. He discussed the question as to whether they arose from Cowper's duct, Cowper's gland, or both. In many cases they arose from the gland, as their deep position proved; but even then, as in his own case, they could be extirpated. Mr. Doran briefly referred to other forms of labial cyst—"hydrocele," sebaceous cyst, cysts of the labium minus, which were often pedunculated, and the large cyst described by Höning, which extended up into the pelvis, but this variety was of vaginal not labial origin. Most of these forms of labial cyst were curable by partial operations. On the other hand, these proceedings were often unsatisfactory in cases of cyst of Cowper's gland. A sinus, as great a nuisance as the cyst itself, was not rarely left behind. Extirpation cured the disease altogether.—The PRESIDENT said he had not infrequently to deal with these cysts, though it was very exceptional to see them so large or with such a thick wall. The specimen shown was probably of very old standing, and the only treatment at all applicable was excision. In a certain number of the cases he had dealt with he had been content with cutting away a portion of the front of the cyst-wall and applying the actual cautery to the interior. All so treated healed quickly without a sinus. He had generally met with them in a state of inflammation in newly married women.—Mr. SHEILD emphasised the importance of thoroughly checking the hæmorrhage in these cases. Secondary hæmorrhage was especially apt to occur in connexion with operations on the scrotum and labium; the warmth and moisture of the parts, together with slight movement, seemed to favour this. He had treated these cysts by excising a portion of the wall and then applying pure chromic acid to the interior. The acid caused a rapid exfoliation of the cyst wall.—Dr. BRAIDWOOD asked if a microscopical examination had been made of the wall of the cyst.—Mr. DORAN, in reply, said that if it were justifiable to remove the larger cysts, the smaller should *a fortiori* be removed also, for the operation was then a simpler one. The question of sinus was the main point, and the object of the operator should be to obviate the possibility of a fistulous opening remaining after the operation. He had seen many cases in which partial excision had failed. Abscess of these glands he had found to be nearly always venereal in origin, or at any rate to be associated with coitus. It was to be remembered that natural dirt was not septic of itself, though it favoured the growth of cocci. The hæmorrhage was usually easy to control, because it could be kept well in sight. The walls of the cyst were composed of pure white fibrous tissue, with thick walled arterioles.

PATHOLOGICAL SOCIETY OF LONDON.

Traumatic Epithelial Cyst of Hand.—Adenoma of Soft Palate.—Parasitic Cysts from Rabbit.—Acute Traumatic and Respiratory Emphysema of Lung.—Right-sided Ulcerative Endocarditis of Heart.—Atlo-axoid Disease.

AN ordinary meeting of this Society was held on Nov. 1st, the President, Sir George Humphry, in the chair.

Mr. RAYMOND JOHNSON exhibited a Traumatic Epithelial Cyst removed from the hand of a boy aged ten years. The boy had fallen two years and a half previously, inflicting a small wound on the upper part of the thenar eminence of the left hand. A swelling had slowly formed beneath the scar. This was exposed by a short incision and found to be an oval cyst, pearly white in colour and three-eighths of an inch in diameter. It lay in the subcutaneous fat and was unconnected with the skin. Examined microscopically, there was found to be a complete absence of fibrous tissue from its wall. Externally there was an epithelial covering consisting of several layers of small cells, and within this were laminæ of horny epidermis. The contents consisted of epithelial scales and granular débris; there was no cholesterin. It was peculiar that no fibrous wall had formed around it, and the name "epithelial cyst" seemed more applicable to it than "dermoid." The occurrence of dermoid cysts on the fingers in positions not explicable on developmental grounds had been long recognised, and there was sufficient evidence to indicate their relation to antecedent injury. Reference was made to such cases recorded in the Pathological Transactions—a case under Mr. Poland in which a cyst developed on the finger in the position of an injury from a piece of sharp steel three years previously; a case under Mr. Bowlby in which frequent pricks with a sewing-needle seemed a likely cause; and, lastly, a case reported by Mr. Barker in which the cyst developed in a finger the end of which had been amputated for injury some years previously. Polaillon (quoted by Mr. Bland Sutton in his Hunterian lectures) described dermoid cysts of the fingers. He mentioned that they occurred in soldiers and workmen, but gave no definite history of previous injury in the cases recorded. Mr. Sutton had also described specimens in sheep and oxen in which injury seemed a likely cause, more especially in the case of a cyst from the shoulder of an ox. It was easy to understand how a small mass of epithelial cells driven into the subcutaneous tissue would, in the course of their growth, develop into a cyst.—Mr. SUTTON said that in more than one case related the tumour consisted of a tucking in of the whole thickness of the skin. He had examined an implantation cyst from an ox which contained hair and one from a sheep which was filled with wool. Lately he had seen another variety in which the implanted structure had grown as a large wart, only that it was upside down and penetrated far into the deeper tissues. Sometimes, after a punctured wound of the cornea or after a cataract operation, the growth of such a cyst might be witnessed from an epithelial graft accidentally implanted on the iris.—Mr. BARKER said that in the case he had shown there was a very tough fibrous layer externally, then came a layer of ovoid cells and then the horny layers; the cyst was full of cholesterin crystals.—Mr. H. B. ROBINSON referred to a paper by Mr. Stabb in which he described two such cysts, one in the palm of the hand and one in the finger. He himself had removed one from the forehead. There was in that case no history of injury, but it was in structure like those described. The interior of the cyst contained cholesterin.

Mr. CHARLES A. MORTON of Clifton showed a Tumour removed by Mr. Harsant from the Soft Palate of a lady fifty-two years of age. It was noticed accidentally on examination of the throat. It was distinctly encapsuled and easily shelled out. The enucleated growth was round, the size of a walnut, not lobulated, but slightly irregular on the surface, and of homogeneous appearance. It grew, as most palate tumours did, on the left side. Microscopic examination showed it to consist of somewhat large cells, arranged in some areas in irregular branching columns, amongst fine, well-formed connective tissue. In one area there were well-formed gland acini in large numbers, and yet close by the same kind of cells that formed the gland tissue became oval and spindle in form like embryonic connective tissue. This Mr. Morton considered evidence of the embryonic origin of the tumour, and that very early in fœtal development, and pointed to the analogy of the structure of the tumour to the complex nature of the ordinary parotid tumour, which was also probably of embryonic origin. He called the tumour "adenoma" simply to classify it with these complex palate tumours, which were all innocent growths, and had been very fully described under that name by Mr. Stephen Paget in St. Bartholomew's Hospital Reports. He wished to call attention to the similarity between the branching columns of cells in his tumour and those described by Mr. Shattock in Sir Wm. Mac Cormac's case recorded in vol. xxxvii. of the Transactions and Mr. Stephen Paget's in vol. xxxviii. Mr. Morton thought it was not a generally recognised fact that large innocent tumours might develop in the soft palate and at the same time project externally under the angle of the jaw. Out of the thirty-one cases of adenoma of the palate collected by Mr. Stephen Paget, not one projected externally, though two were so large as to be difficult of removal through the mouth. Mr. Dobson of Bristol had described in St. Thomas's Hospital Reports many years ago a fibro-adenoma which was so large that it could hardly be removed between the teeth. This growth (which occurred in a young woman aged twenty-two) developed in the soft palate, and also formed a swelling the size of a chestnut under the angle of the jaw, which, when the tumour was removed from the palate, was found to be part of it. The case had been published as "a case of surgical interest" and had therefore not been noticed by writers on tumours of the palate. Dr. King of Hull brought a similar case before the Medical Society of London in 1871.—Mr. STEPHEN PAGET referred to the complex structure of these growths. They occurred in people either between

fifteen and twenty or between forty and fifty. They grew slowly for years, were usually discovered by accident, and, like the tumours of the parotid, were much more common on the left side. They occasionally gave much trouble from hæmorrhage when they were removed. Not only the adenomatous but the sarcomatous growths of the soft palate could frequently be shelled out from their bed, but this as a rule could not be done when the patients were old or when the growth increased rapidly and in a downward direction.—Mr. SHATTOCK had frequently studied these tumours, but could not make out whether they should be classed with the glandular or the connective-tissue tumours. He thought that on the whole they belonged to the latter group, and many were to be described as "cylindromata," having cells of connective-tissue origin embedded in tissue of a hyaline structure; it was possible that some of them were instances of a mixture of glandular and connective-tissue neoplasms. Such a mixture occurred in common moles.

Mr. H. B. ROBINSON showed the hind-quarters of a tame rabbit. On the inner side of the right thigh and at the back of the left leg there were cysts. There was also a large one below the jaw, and two or three imbedded in the connective tissue of the back. They were of the size of oranges. The cysts had an external bladder, on opening which there were seen groups of bodies like bunches of grapes, containing calcareous granules. They turned out on examination to be scolices of a tænia inverted. The head showed two rows of hooklets, an outer smaller and an inner larger row. They were twenty to twenty-four in number and there were six suckers.—Mr SHATTOCK said that an object so rare as a tapeworm with six suckers was worthy the attention of a committee, and on the motion of the President the specimen was referred to the Morbid Growths Committee.

Dr. F. C. TURNER showed two specimens of Emphysematous Lesions of the Lung. The first was obtained from a child who died, after being run over, from laceration of the liver, with hæmorrhage into the peritoneal cavity. It showed a fringe of emphysematous vesicles along the inferior border of the lower lobe, which was attributed to opening out of the angle between the chest wall and the diaphragm, by the lateral bulging of the chest compressed antero-posteriorly, and by the simultaneous thrusting down of the liver, crushed between the wheel and spinal column. The second specimen consisted of the lungs of an infant which died with tubercular disease of one kidney and ureter, showing extensive tracts of interstitial emphysema in the anterior parts of the lungs and some scattered emphysematous vesicles over the surface of the upper lobes, in some of which miliary tubercles were visible. The bronchial glands were caseous. The child was marasmic and had suffered from diarrhœa, but not from cough. The extent of the lesions was regarded as evidence of their having been produced by compression of the expanded lung in straining. Some observations were made as to the insufficiency of the expiratory theory to account for an extent of emphysematous lesion capable of greatly interfering with the functional capacity of the lungs, and as to the ultimate dependence of substantive emphysema with barrel-shaped chest on inspiratory expansion associated either with recurrent bronchitis or with some nutritive defect of the pulmonary tissue, diminishing its elasticity and resistance to expansion.

Mr. J. JACKSON CLARKE showed the Heart of a young woman aged twenty-three, who had been under the care of Dr. Broadbent in St. Mary's Hospital. She died of right-sided ulcerative endocarditis. There was an extremely loud bruit, which Dr. Broadbent described as the loudest he had ever heard. There was great stenosis, probably congenital, at the beginning of the infundibulum and consequent hypertrophy of the right auricle. About an inch above the narrowing, which admitted only the tip of the little finger, there were only slight indications of the pulmonary valves, which were all but destroyed by the ulcerative process. The pulmonary artery and its main branches presented extensive ulcerations. Large masses of clot plugged the larger branches of the pulmonary arteries and the lungs contained purulent infarcts. Masses of streptococci were present in the vegetations. Mr. Clarke referred to a similar case which had been under the care of Dr. Maguire.

Mr. CLARKE also showed a Section of the Cervical Vertebræ of a girl aged nineteen, who died from atlo-axoid disease. When admitted into St. Mary's Hospital under Mr. Owen the patient was in the gravest possible condition. Mr. Owen found a retro-pharyngeal abscess and at once opened it behind the sterno-mastoid after fixing the head and neck. In spite of complete drainage, fixation and rest in bed the patient did not improve. Finally Cheyne-Stokes breathing and coma ushered in the end. After death it was found that the abscess had opened spontaneously by a minute pore before it was drained surgically. The atlas was displaced more than half an inch forwards on the axis. The first and second cervical nerves were involved in inflammatory material. The atlas and axis were extensively affected with caries. It was ascertained that the patient had for ten years suffered from occipital pain, which latterly had become most intense.

The following card specimens were shown:—Mr. D'Arcy Power (for Mr. G. N. Stephens): (1) Specimen of Lepra Mutilans; (2) Calculus Encysted in a Child's Bladder.—Dr. E. C. Perry: Secondary Sarcoma of the Small Intestine.—Dr. Ormerod: Stenosis of Pulmonary Valves.—Recent Specimen—Dr. Voelcker: Primary Carcinoma of Pancreas; Thrombosis of left Common Iliac Vein; Embolism of Pulmonary Artery.

Reviews and Notices of Books.

A Treatise on Hygiene and Public Health. Edited by THOMAS STEVENSON, M.D., and SHIRLEY F. MURPHY. Vol. I. London: J. & A. Churchill. 1892.

A COMPREHENSIVE work on hygiene and public health has for some time been much needed by those engaged in the study and practice of this subject. The additions which during recent years have been made to our knowledge of preventive medicine and of the conditions which affect health demand larger treatment than is possible in a handbook. The suggestion made by the late Professor de Chaumont that a treatise should be issued containing essays by various authors was therefore well worthy of adoption, for it is obvious that special knowledge is required for the discussion of each of the several subjects which come within the scope of such a work. In the treatise the first volume of which is before us this course has been followed, and we may congratulate the editors and publishers on their success in obtaining the coöperation of contributors so well qualified to share in its preparation.

A brief but carefully prepared paper on Air is contributed by Professor J. Lane Notter; and it is interesting to observe that the author is, unlike other noted authorities, disposed to assume a causal relation between the air of sewers and diphtheria. This subject is only just touched upon, and then a reference is made to certain investigations by the late Mr. Spear for the Local Government Board. The air of graveyards is credited with the production of cholera and even of scarlet fever; in India, Dr. Notter says, it is well known that cholera assumes a more severe and fatal type in stations where barracks are built in close proximity to the sites of old burial grounds. The evidence as to scarlet fever rests upon an account given four years ago of an outbreak of scarlet fever in the family of a Yorkshire rector whose garden included a part of a disused burial ground, in which had been buried thirty years before a number of persons who had died from this disease. The outbreak in the rector's family followed the disturbance of this ground. Such occurrences undoubtedly deserve careful investigation. They are necessarily rare and are certain, in the first instance, to be received with some incredulity, and the adoption of this theory by Dr. Notter will no doubt lead to closer inquiry into the question whether the air of graveyards can, under these exceptional circumstances, be productive of disease.

Dr. Notter's paper is followed by an admirable article on Warming and Ventilation by Mr. W. M. Shaw. This is perhaps one of the most valuable contributions to the work, for the author has in little more than a hundred pages given a clear and comprehensive account of this subject. After discussing the physical properties of air and devoting two sections to water in the air and dust and smoke, Mr. Shaw

considers in detail the principles of ventilation, dividing the process into general circulation and local circulation and discussing the effect of different characteristic conditions, finally applying these principles to special cases. A valuable account is given of the various ways of producing heat and the economy of production, and, later, of the method of carrying heat from one central furnace to rooms more or less distant from the furnace. The whole subject is treated in a thoroughly scientific manner and the argument is illustrated by numerous formulæ.

Mr. Shaw's article on Ventilation is followed by papers on Meteorology and Climate; the former by Mr. G. H. Symons, F.R.S., and the latter by Dr. Theodore Williams. Mr. Symons' contribution is practically a concise account of meteorological conditions and instruments; while Dr. Williams discusses the influence of these conditions on health, and gives in brief form an excellent account of different climates which will be not less useful to the practitioner than to the health officer. Water is treated by one of the editors (Dr. Thomas Stevenson), who gives in some eighty pages a good summary of the subject. Considering the question of the self-purification of rivers, the author fully recognises the changes which are effected in running waters; but he writes cautiously as to the distance which is required to render fit for domestic purposes the water of a river which is excrementally polluted, and he states that "observation appears to show that a flow of twenty miles in a river is not sufficient to destroy the germs of typhoid fever." The section on Lead Pollution will be read with much interest. Dr. Stevenson states definitely that neither the silica theory nor the acid theory of the action of water on lead accounts for the whole facts known.

Dr. Copeman's article on Soil is a laborious piece of work, giving evidence of careful study of the vast amount of literature of this subject which is now available. The author has had full regard for bacteriological considerations in its treatment. Referring to the question of lead pollution, Dr. Copeman evidently attaches greater weight than Dr. Stevenson is disposed to do to the theory that the ability of some waters to dissolve lead is due to bacterial life, and he cites the memorandum by Mr. W. H. Power contained in the report of the medical officer of the Local Government Board for 1887. The paper will prove extremely useful to those who have not access to the works of foreign writers, especially of those of the Germans, by whom the question of soil has been specially studied.

Food has been treated by Dr. Sidney Martin in an article which contains a valuable account of dietaries and foodstuffs, and which will serve well as a trustworthy source of reference. This article is followed by a short paper on Meat Inspection, by Dr. E. W. Hope, who later in the book contributes an article on Slaughter-houses, both of which are evidently based upon much personal experience. Clothing is discussed by Dr. G. V. Poore in a practical article, in which account is given of the materials used for clothing as well as of the articles of clothing employed for different parts of the body. Physical Education is treated in considerable detail and with much common sense by Mr. Frederick Treves, who, after discussing the effects of exercise, deals in a practical manner with each of the more common sports. As a guide to the management of the exercise of children and young adults this article deserves the study of all. The article on Baths, by Dr. Hale White, includes an account of the different kinds of baths and their physiological action.

An admirable paper on the Dwelling is from the pens of Messrs. Gordon Smith and Keith Young. In this article are discussed the house usually occupied by a single family, houses occupied by more than one family, prisons, barracks, schools, general and special hospitals, including those for cases of infectious disease. This article gives excellent advice as to the arrangement of public institutions and is freely illustrated with plans showing the different systems which have been adopted. It is followed by a paper on "Hospital Hygiene" by Mr. H. G. Howse, who in dealing with the management of such institutions shows the results which have been attained by antiseptic treatment.

The Disposal of Refuse is treated by Professor Corfield and Dr. Louis Parkes in a carefully written article which includes a full discussion of different methods of conservancy and of the treatment of sewage. Offensive and Noxious Businesses is from the pen of Dr. T. Whiteside Hime, who includes in his paper an account of the various trade processes causing effluvium, nuisance, or in connexion with which there may be chemical poisoning, together with the means which should be adopted for the prevention of nuisance or injury. It is impossible in the space at our disposal to discuss in detail the work of the several authors who have contributed to this volume, but we may briefly say that the publishers have been fortunate in securing editors of such acknowledged ability and standing, that the editors are to be congratulated on their choice of contributors, and that the work has been well done. If the next volume is compiled with the same care and completeness which characterise the first one, the want of a comprehensive book of reference on public health will have been admirably met. The work ought to have a wide circulation, not only in England, but wherever the English language is spoken; and it is likely to become an essential book of reference with all who undertake any duties which involve considerations of health.

Swin, Swale and Swatchway; or Cruises down the Thames, the Medway and the Essex Rivers. By H. LEWIS JONES, M.A.; assisted by C. B. LOCKWOOD. London: Waterlow and Sons, Limited. 1892.

THE estuaries of the Thames and Medway, with their infinite complexity of sands, channels, rivers, buoys and lights, afford to the fortunate few a health-resort of unrivalled interest and value. After a hard week's mental toil to run away from London and arrive in an hour or two at Port Victoria, Queenborough, Leigh or Southend, and to find there the trusty three-ton yacht which the holiday-maker and his partner have known so long and can manage so well, revivifies the most jaded intellect. Running out of the small and secluded port where his ship has been lying, with simple but sufficient stores, he embarks on cruises which may be almost indefinitely varied, and any one of which may be completed in a day or two. Frequent hard work, occasional discomfort and even anxiety attend upon the enterprise; but these form a great part of the charm and are amply compensated by the placid sea and river views, the sunrises and sunsets, and the simple meals which go with them. This little book, smartly written and illustrated not only by photographs, but also by interesting antiquarian and historical comments, will be incomprehensible to the many, but keenly interesting to the few. With the latter class the minute accuracy of the topographical details, the sea-wisdom of the directions for guidance in all but unknown creeks and channels, are simply fascinating. That anyone who has tried small yacht sailing in out-of-the-way corners and has learned its many charms, its freedom and its exceeding cheapness should prefer a "Saturday to Monday" at the seaside seems remarkable. Of course, small yacht sailing requires skill and much experience, and unless one at any rate of the partners possesses these qualifications a paid hand is essential. But those who wish to learn to sail should reserve the paid hand for emergencies and, subject to his criticism, should do all the work for themselves. Steering from the Thames into Hole Haven above Canvey Island after dark and anchoring not too

near the powder magazine or the steep mud-banks is a very good exercise, and in case of the worst there is an inn close by.

The Physiology of the Invertebrata. By A. B. GRIFFITHS, Ph.D., F.R.S. Edin. Pp. 477. London: L. Reeve and Co. 1892.

THE title of "Anatomy and Physiology of the Invertebrata" would be more appropriate than that which Dr. Griffiths has given to his treatise, for many paragraphs are as much anatomical as physiological. It is indeed questionable whether anyone is competent to write a book devoted exclusively to the physiology of the lower animals—so much is conjectural in regard to the functions of the various organs, so little is positively known. Even in the case of such a characteristic organ as the eye of insects Dr. Griffiths writes: "The sense of sight must be keen in the insecta, but their mode of vision is essentially different from that of the higher vertebrata," and he quotes, apparently with approval, Professor C. Lloyd Morgan, who remarks: "Remember their compound eyes, with mosaic vision, coarser by far than our natural vision, and their ocelli of problematical value and the complete absence of muscular adjustments in either the one or the other. Can we conceive that, with organs so different, anything like a similar perceptual world can be elaborated in the insect mind? I for one cannot." If this holds good of the eyes of insects, what can be said of many other organs whose functions are far more obscure? The method adopted by Dr. Griffiths is to devote successive chapters to the several functions. Thus the functions of digestion, absorption, the blood, circulation, respiration, secretion and excretion, nervous system, organs of special sense, movements and locomotion, and reproduction have each a separate chapter in which the special function is fairly discussed. The imperfection of our knowledge renders the account given under these heads, however, rather disjointed and fragmentary, and very soon tires the reader. It is, in fact, a book of reference. At the same time it must be admitted that Dr. Griffiths, besides giving the result of his work in many cases as an original investigator, has spared no pains to make himself thoroughly familiar with all recent researches. In the chapter on Respiration, for example, he gives a very full account of the colouring matters of the blood in the invertebrata, together with the relation of these pigments to the respiratory function. This account contains references to the observations of Mr. MacMunn, Professors Geddes, Lankester, Bunge and others, and there is much under this head that cannot be found in the ordinary text-books. The relations of many insects to carbon dioxide are remarkable. The author states that he found that some can resist the action of an atmosphere containing from 40 to 70 per cent. of carbon dioxide, which may perhaps account for their early appearance in the history of the earth when the atmosphere was probably more highly charged with this gas than at the present time. Dr. Griffiths kept a stag beetle alive for six days in an atmosphere containing 60 per cent. of chlorine, which to the lungs of higher animals is a very poisonous and irritating gas. Mr. MacMunn's investigations on animal pigments obtain an amount of recognition that must be extremely satisfactory to him, for on casually opening the volume we were struck with the circumstance that Mr. MacMunn's name appears sometimes two or three times in eighteen pages successively—not that we at all undervalue that gentleman's researches, but in truth they constitute rather dry reading. A good description is given of the green glands of the decapod crustacea, the functions of which Dr. Griffiths' own researches have done so much to elucidate. The curious idea was at one time held that these glands were the auditory organs. The conclusion at which he has arrived is that they are urinary organs, the secretion containing uric acid and traces of guanin. In connexion with this he gives an important table, also compiled from his own investigations, showing the different modes in which the kidney is represented in the several groups of the invertebrata.

Some errors occur in the account of the determination of the rapidity with which motor nervous excitation is transmitted in the lobster. The whole paragraph requires to be rewritten to render it intelligible. A few typographical errors also occur, as, for example (p. 306), "polyprite" for "polypite" and (p. 218) "cornynactis" for "corynactis"; p. 217, "sagarita" for "sagartia"; p. 67, "unis" for "nnio"; p. 444, "Grundzünge" instead of "Grundzüge"; but, on the whole, the editing is well done. The treatise will prove useful to those who are students of comparative physiology and is the only one we possess in the English language.

The author states his indebtedness for some of the illustrations to his sister, Miss M. Griffiths, and they reflect credit on her skill.

Analytical Records
FROM
THE LANCET LABORATORY.

BRAVAIS WINE AND BRAVAIS ELIXIR.
(NOBLET AND CO., THE BRAVAIS WINE COMPANY, 5, AVENUE DE L'OPÉRA, PARIS.)

THE preparation of this wine was suggested by M. Bravais, the analytical chemist to whom we owe the original formula for the preparation of dialysed iron. It contains the tannates of cocaine, caffeine and theobromine, which embody the active principles respectively of the coca plant, the kola nut, and the interesting Brazilian shrub, *Paullinia sorbilis* or Brazilian cocoa. As affording an excellent vehicle for these principles a superior sherry (Pedro Zimenes) has been employed. The genuine character of the wine is made evident by the following results of an analysis which we have recently made. On evaporating the wine to dryness, and extracting with ether after the addition of sodium carbonate, the ether yields a crystalline residue, which produces numbness on the tip of the tongue, and which, with hydrochloric acid, forms characteristic crystals of cocaine hydrochlorate. If the residue, after extracting the cocaine, is then treated with chloroform, beautiful silky needles of caffeine, identical also with guaranine, are obtained. The presence of tannin is sufficiently indicated by the perchloride of iron test. In addition to these results the following were obtained: Alcohol, by weight, 12·69 per cent.; by volume, 15·68 per cent.; residue, consisting of sugar and the active principles alluded to, 16·29 per cent.; mineral matter, 0·37 per cent. The wine resembles a dark sherry, is generous to the taste and doubtless possesses properties of distinct therapeutic value referable to the tonic and invigorating principles the presence of which our analysis has confirmed.

The composition of the elixir is founded on similar lines. It is practically a rich curaçoa containing caffeine and cocaine. The presence of tannin and cocaine, however, was not clearly indicated. Analysis furnished the following data: Sugar and extractives, 39·33 per cent.; mineral matter, ·017 per cent.; alcohol, by weight, 32·69 per cent.; by volume, 39·25 per cent. On dilution with water the elixir becomes opaque owing to the separation of essential oils, but the opacity vanishes at once on the addition of ether. It is a pleasant liqueur, and its value is of course enhanced by virtue of the stimulating and restorative ingredients present.

EXTRA QUALITY ÉPERNAY.
(PERIGEUX ET CIE., ÉPERNAY.)

An excellent sample of the 1889 vintage from the famous Épernay district. It is an agreeably dry wine, of fruity

character, yielding 3·53 per cent. extractives and 0·12 mineral salts. On distillation 100 volumes afford 12·77 volumes of alcohol, equal to 10·31 per cent. by weight, or in terms of proof spirit 22·38. The ash contained a distinct quantity of iron. The wine is evidently of sound quality and none the less satisfactory because it is entirely free from added preservatives and from metallic contamination.

SPECIAL GLEN URQUHART HIGHLAND WHISKY.

(HENRY URQUHART, LONDON.)

There is no doubt that whisky is all the more wholesome for being stored in wood for a few years. The reason that whisky mellows in wood and not in the slightest degree in bottle appears to depend upon the selective power of the wood to absorb and retain the higher alcohols of which amylic or fusel oil is a type. Glen Urquhart is described as an old blended spirit, and judging from the character and smoothness of its flavour it is properly so described. It contains only 0·11 per cent. extractives and merely a trace of mineral matter. The alcoholic strength is somewhat below the average, as may be seen from the following figures: Alcohol, by weight, 40·30 per cent.; by volume, 47·67 per cent., or 83·54 proof spirit. In terms of proof spirit, in fact, it is only eight degrees above the limit of strength fixed by the Excise.

TABLOIDS OF COMPRESSED ERGOTIN.—THE "ÉLITE" TOILET LANOLINE CREAM.

(BURROUGHS, WELLCOME & CO., SNOW-HILL BUILDINGS, E.C.)

The active principles of ergot are not definitely known, although an alkaloid which appears to be identical with Wenzel's ergotinine has been separated. Ecboline has also been obtained by Wenzel, but a research by Dragendorff tends to show that both Wenzel's ergotinine and ecboline are inactive. From ergot have also been obtained scleromucin, sclerotic acid and as inert principles a red colouring matter scleriodin and two crystalline substances, which are without physiological action. The above tabloids are sugar-coated and contain a glistening brown mass which, when extracted with alcohol and acidified with sulphuric acid, gives a brownish-red solution absorbing the green and a large section of the blue rays in the spectrum. This useful administrative form is calculated to give the drug additional value and probably more extended application. Each tabloid is stated to contain three grains of Bonjean's extract.

Lanoline cream is intended for toilet purposes, for which, in fact, no other unguent is better fitted. It is readily absorbed and has no tendency to become rancid, a property which seems to be concomitant with its refractory behaviour towards alkalies; it does not saponify readily. The "élite" cream is evidently worked up or emulsified with water delicately scented with rose extract: on heating, water is given off, accompanied by a fragrant smell, while perfectly pure and transparent lanoline oil remains.

MIST. BISMUTHI OXYCHLOR. c. PEPSINA.

(A. G. DRUCE, 3, MELVILLE TERRACE, EDINBURGH.)

The main novelty in this preparation lies in the fact that the oxychloride of bismuth is used in its composition in preference to the subnitrate or other salts. This is in all probability a useful departure and doubtless adds to the remedial action of bismuth. The preparation also contains pepsin, the activity of which we have ascertained by experiment. The oxychloride occurs as a very fine powder in suspension in a syrupy fluid, which on examination proves to be glycerine. The salt separates, however, on prolonged standing, but a little shaking suffices to give a uniform mixture again. We do not know what the action of oxychloride of bismuth upon glycerine may be—if perchance there is any at all,—but we noticed a distinct pressure in the bottle, accompanied by slight effervescence, on withdrawing the cork.

SUPERFATTED BORIC ACID SOAP.

(R. SUMMER & CO., LIVERPOOL.)

This well-made soap is free from excess of moisture and alkali and contains a suitable proportion of boric acid. It is accordingly endowed with properties of some antiseptic value. The test for boric acid was satisfactory.

SANITAS CREAM.

(THE SANITAS CO., LTD., BETHNAL-GREEN, E.)

This preparation consists of an ointment strongly impregnated with a soluble variety of sanitas oil. It has a pleasing and persistent odour of sanitas and dissolves entirely in water forming a soapy solution. An oil separates from the solution on addition of acid, and the clear liquid on evaporation yields a sodium salt. The preparation may therefore be regarded as a soft sanitas soap possessing distinct antiseptic and oxidising powers, and therefore available for use with certain advantages for dressing burns and other wounds, or as a cleansing and effective mouthwash.

HOVIS BREAD AND BISCUITS.

(S. FITTON AND SON, FLOUR MILLS, MACCLESFIELD.)

Evidence is forthcoming almost every day that the old and faulty system of preparing bread hitherto exclusively adopted, which consisted in producing a perfectly white loaf at the expense of some of the most valuable constituents, will soon be entirely superseded by the more scientific method by which the maximum amount of nourishing material of the cereal both organic and inorganic is secured. Our examination of the samples enumerated above, which are skilfully prepared on the lines indicated, proved entirely satisfactory. Hovis bread is made from flour stated to contain 2 per cent. whole meal and 25 per cent. of germ flour. Germ flour itself contains no less than a third of its weight of nitrogenous matter, 2·57 per cent. phosphates, 15·62 per cent. fatty matters, 1·72 per cent. fibre, and a third of its weight of starch. Its composition signifies, in fact, a concentration of the nourishing elements of wheaten flour into a third of its bulk, to the exclusion of more than half of the starch. As affording a check on these figures, we have submitted the sample of bread to careful analysis and find that its composition may be thus represented: Moisture, 49·41 per cent.; mineral matter, 1·25 per cent. (containing an abundance of soluble phosphates); starchy matters and fat, 39·04; nitrogen, 1·63 per cent., equal to albuminoids, 10·30 per cent. According to this its food value, both as regards nitrogen and phosphates, is, broadly speaking, double that of bread made with ordinary wheaten flour. Under the microscope the structure presented is that of well-cooked bread of uniform texture containing a due proportion of fibre, which, it is important to add, consists of fine and not coarse particles. Not less satisfactory is its property of keeping moist, and therefore palatable, for several days. The biscuits are made of the same flour; they are attractive in appearance, crisp and of excellent flavour. It will be conceded that a system which produces impoverished food is to be deprecated, while a system which tends to secure rather the enrichment of food is strongly to be commended. The system under notice meets with our entire approval.

LONDON AND COUNTIES MEDICAL PROTECTION SOCIETY, LIMITED.—A meeting attended by many of the leading members of the medical profession of Derbyshire was held at the Royal Infirmary, Derby, on Oct. 21st, for the purpose of forming a division of this Society for Derbyshire and adjacent parts. Dr. Greaves of Derby, who occupied the chair, spoke in favour of forming such a division for Derby, and stated that from facts within his knowledge there was a necessity for combining for the purpose of protection against unjust attacks and other evils to which members of the medical profession were especially liable. It was eventually unanimously resolved to form a Derbyshire division, and the following officers were appointed:—President: Dr. C. Greaves. Vice-Presidents: Dr. Curgenven, Mr. T. Johnston (Belper) and Mr. Symes. Secretary: Dr. C. H. Taylor.

THE LANCET.

LONDON: SATURDAY, NOVEMBER 5, 1892.

WE would direct the attention of our readers who are interested in the establishment of a Teaching University in London to the able and judicious article which we publish on page 1062. There can be no doubt, as Professor ERICHSEN so clearly shows, that the opportunities for clinical instruction that exist in this metropolis are unrivalled either in Europe or in the United States of America. But these opportunities are arranged without any regard to the requirements of the medical student. In many centres of medical instruction we find some such system as the following—viz., one large hospital which possesses an enormous number of beds and around which the scientific laboratories &c. are congregated, every aspect of medical teaching being thus focussed. In London we have a system which is the direct opposite. Eleven teaching hospitals have 4542 beds divided amongst them, whilst twenty-seven Poor-law infirmaries in the metropolitan area contain an aggregate of 13,825 beds. We need not refer to the general hospitals which have no schools attached to them, or to the special hospitals, or to the enormous mass of out-patients who are daily seen at the various London hospitals. We would only incidentally point out that during the last month more than 4000 patients were under treatment in the metropolitan area in the fever hospitals alone. The immense amount of material for clinical teaching afforded in the metropolis has never perhaps been so forcibly put forward as by Professor ERICHSEN, and we commend the consideration of it to the Royal Commission. The obvious deduction is that these opportunities should be fully utilised. It is notorious that at the present time this is not the case. A student at a London medical school in the course of his career there can, however diligent, learn no more than is placed before him by his teachers at that school. He is practically debarred from acquiring a knowledge of any other advances in science and new procedures in diagnosis and treatment which he might meet with elsewhere. We need not urge how important it is for future practitioners to be *au courant* with the progress of medical science and with its bearing on the treatment of disease in its multifarious forms. But in London, with its large number of medical students, one centralised institution for the teaching of the sciences ancillary to medicine would be most disadvantageous. There is ample room, and there would be a sufficient number of students for at least three or four fully equipped scientific schools and their necessary laboratories, and this would secure due competition among the teachers. For post-graduate clinical teaching the case is somewhat different, and all the material in the metropolis and the services of every individual teacher should be available in the case of each student of medicine. The practical question is—How can the medical student who obtains his education in this unrivalled centre gain the greatest advantage from these opportunities? To this query Professor ERICHSEN has given a complete answer. Whilst *in statu pupillari* the student should follow the teaching of his professors and lecturers at the medical school to which he is attached. At this period of his career he will probably gain nothing by endeavouring to follow the teachings of any other lecturer, however distinguished, at another medical school. If he attempts to avail himself of the instruction of the various surgeons and physicians who may have attained a reputation through professional eminence or by reason of strong individuality as teachers at various schools, he will probably only waste his energies without having obtained any definite reward in the shape of exact knowledge. But if, after he has passed the examinations necessary for a diploma, he were able to attend for a year or two upon properly selected courses of special teachers he would learn much, and the knowledge thus acquired would be to him an immense boon in his later career. To secure these advantages Professor ERICHSEN has made a most important practical suggestion. Every hospital and medical school should, he suggests, be federated, and then, instead of the present system of scattered post-graduate courses, the various institutions in the metropolis would be available for post-graduate teaching. But this result can only be obtained by the federation of all the institutions under the guidance of a local university.

The University of London has entirely failed to bring together the medical resources of the metropolis for such a purpose. It has contented itself with a mere examination standard, and has done nothing towards collating the educational advantages which London possesses in the matter of the teaching of medicine, surgery and the collateral sciences, and we fail to see how, under any *régime* like the present, such advantages can be properly utilised. A purely examining board can do nothing towards the attainment of this most desirable end. It is very doubtful if any reconstitution of the University can enable it (whilst carrying out at the same time its special function as an examining board for the empire) to perform this duty, which ought to be one of the greatest functions of a local University for London. For these reasons, amongst others, we hope that the Royal Commission may see its way to recommend the formation of a local university, and such federation would then be one of the first matters to secure attention. Incidentally we would remark that in Professor ERICHSEN'S article one statement has been made under a mistaken impression. Two years of residence are stated to be a necessary requirement for all candidates for a full degree at the Scottish universities, as well as at the teaching universities of England. There is one exception to this—viz., that at the University of Durham an attendance for one year on the lectures and hospital practice at the Medical School at Newcastle-on-Tyne is all that is at present required for the medical degrees of the University of Durham.

THIRTY-TWO years' missionary work in the highlands of Ethiopia entitled its hero, Cardinal MASSAIA, to all the honours that attended his declining years and also to the beautiful monument just unveiled to his memory, with every accompaniment of admiration and respect, in the Capuchin Church at Frascati, on the Alban Hills. These outward

tributes are but a feeble expression of the gratitude owed to him by humanity. Alone and single-handed, half a century ago, he dared to penetrate into regions where European foot had seldom or never trod, and though his errand was the diffusion of the light of Christianity, his mode of carrying it out was as signally and fearlessly his own as the routes he opened up and the weapons he fashioned as well as found. GULIELMO MASSAIA was no common missionary, proceeding on well-worn lines and using traditional methods. He had a profound knowledge of his fellow man in every grade of civilisation, and in his dealings with him he brought that knowledge to bear through every possible channel. He taught the benighted Shoans and Gallas what was meant by civilisation, and proved to them that the shortest cut to it was Christianity. He took care of their bodies as the first step to enlightening their minds. He made a special study of the climatic and health conditions under which they lived and moved, and accurately observed the diseases which they generally inherited. When an epidemic prevailed he studied its origin, its course, its issue, the circumstances that encouraged or checked it and the remedies to which it yielded. He inspired respect among his savage congregations by his fearlessness and confidence amid shafts that "fly in darkness," and won them to his gospel teaching by the personality he typified and the example he gave. In the dominions of the Shoan King MENELIK he faced and subdued a formidable outbreak of small-pox, and he prevented its return by rigorous and systematic vaccination. Although without professional qualification he had yet acquired a knowledge of science, and this he used on every possible occasion with intelligence, energy and effect.

It is gratifying to see that the methods of MASSAIA are receiving increased attention on the part of those engaged in mission work, and that, irrespective of religious differences, the societies of the several Protestant churches are not averse to profit by the example of that of the parent from which they are detached. In one direction they might take yet other leaves from the Roman Catholic book. Before us lies a publication issued under the approval of the Vatican and circulated widely among the priesthood—among all those, in fact, who, abroad as well as at home, are brought into daily contact with their fellow man in all the occurrences and crises of domestic life. It is the "Medicina Pastoralis" of Dr. CAPELLMANN, a work which has reached nine editions in its German original, and three editions in the Latin dress it has assumed for those to whom German is an unknown tongue. It supplies, from the pen of a thoroughly qualified practitioner, the information which an intelligent ecclesiastic might be trusted to apply in the absence of the regular medical man. Cautiously compiled, it addresses itself to those who, as members of a liberal profession, have been taught "to know what knowledge of a subject means," and who will therefore use its advice and its prescriptions with the circumspection and under the safeguards which the half-educated sciolist or amateur so invariably despises. It is, in short, an illustration of what has long been an honourable tradition of the Church of Rome—that of maintaining a respectful and loyal attitude towards the profession of medicine, and at the same time supplying to those of its priesthood who are brought into relation, whether as pastors or as missionaries, with flocks unfavourably circumstanced, a carefully arranged set of rules and prescriptions. Thus equipped it is not difficult to understand how, in past times, the Jesuit missionaries became active instruments in diffusing in unexplored countries their knowledge of diseases and of remedies. Hand in hand with their spiritual teaching they bore the light of medical knowledge into uncivilised regions, and repaid the profession, on whose armoury they drew, by bringing back to it descriptions of maladies and their treatment, of drugs and their efficacy, of poisons and their antidotes, which have laid scientific medicine under obligations to them for all time. The opportunities of the medical missionary are great, often unique, and it is to increase the effectiveness with which these may be utilised that we think the attention of the various societies might be directed.

That their work is in need of every adjunct to its efficacy is on all sides admitted, and competition between them cannot fail to have its usual wholesome results. Let it be realised in its full breadth and depth how essential it is that religious inculcation should go side by side with physical health or rehabilitation and the medical arm of missionary enterprise will be as jealously trained and equipped as the spiritual. Public opinion is rapidly ripening to a recognition of this interdependence of the two professions, and its material or moral support will be the more liberally and efficaciously bestowed as it sees that they work both at their full strength and both in harmony. The multiplication of such institutions for medico-missionary training as that which has so long and so successfully been in operation at Edinburgh will be a next step to the closer and more effective alliance of the two callings, and we shall every year be more and more spared the not very reassuring spectacle of relays of missionaries being sent out at great expense and with high expectation to benighted regions and not a medically qualified man among them to supplement and sustain their efforts. The other day, as a result of the "forward movement" taken fifteen months ago by the directors of the London Missionary Society, nearly forty missionaries were added to their foreign staff. Of these, twenty-six bade farewell on Wednesday, the 26th ult., to their friends in Exeter Hall before leaving for their posts, and nothing could have been more touching or more impressive than the ceremony. Well-wishers to the cause, however, must have missed among the nobly inspired band, male and female, the due proportion of those medically qualified; and though medicine was by no means unrepresented among them, still the addition of many more thus equipped would have inspired a better grounded anticipation of success. Quite apart from the spiritual interests of the communities among whom the missionary labours—all-essential as these interests are—the political interests also at stake are not to be overlooked. As Sir CHARLES AITCHISON recently showed, we are indebted to our hold on our great Indian dependency more to missionary effort than to any other cause, and a master-force in that effort has been the medical contribution. In newly acquired regions, indeed, where we have to encounter a competition unknown to us in India, the reinforcement of our influence and the consolidation of our control is to be effected by every means available. These are not the times nor are those the regions where we

can afford to underman our expeditionary enterprise or to leave its equipment defective at any point. The missionary work is one of the most powerful weapons at our command, and in that work the medical element is not the least efficacious. It will be our own fault if, recognising these facts, we allow ourselves to be outstripped by foreign competitors who derive from the church of their fathers a traditional skill in pressing every missionary qualification into their service, the medico-missionary included.

YOUNG men in their conflict with temptation to sexual vice often suffer under the disadvantage of receiving but little help from those to whom they ought to look for it with confidence. Few parents have the knowledge and the wisdom to tell their sons the most important truths about the sexual passion just at the time when it is becoming developed in them, and the latter are therefore left an easy prey to their strange desires and to those "lewd fellows of the baser sort" who are always at hand to corrupt innocent youth. If it is true that to a very large extent parents are unmindful of one of their gravest responsibilities, it is no less true that the medical profession has often failed in its duty in connexion with this subject. Medical writers and medical men generally are too often silent on this matter, and, unfortunately, when the silence has been broken it has not always been with words of truth and soberness. We are constantly hearing and saying that "knowledge is power." Yet we find that little effort is made to impart the knowledge which would largely aid in preserving the virtue of the young, and the most pernicious teaching of those who, for the lowest of reasons, propagate error is left unnoticed. Knowledge alone will never make a people virtuous, but it is an invaluable aid to those who are striving to control their passions. Seeing on all sides the terrible physical, mental and social havoc wrought by sexual vice we feel that the medical profession should do its utmost to stem the evil, and, at any rate, should give utterance to the truth with no uncertain sound. What are the physiological facts that ought to be proclaimed by the medical profession? Mainly these. In the first place, that occasional involuntary emissions of semen during sleep, and often in association with libidinous dreams, are natural occurrences in unmarried continent men, and are neither the cause nor the consequence of disease. The emissions are most frequent between the ages of eighteen and twenty-five; they vary in frequency in different men, but are favoured by sedentary occupations and by lewd thoughts. The subjects of these emissions sometimes complain of various sensations of malaise, which they attribute to the depressing influence of these losses; but it is a striking fact that such symptoms are only met with in those who have an exaggerated or erroneous conception of the significance of the discharge, and that they quickly disappear when their real meaning and causation are understood. To regard such a physiological occurrence as a disease and name it "spermatorrhœa" is a very serious error.

The second fact we wish to insist upon is that sexual continence does not beget impotence, and that the all-prevailing cause of impotence is prolonged sexual excess. In support of the opposite conclusion appeal has been made to analogy. It has been pointed out that unused muscles and bones waste, and therefore, it is urged, it must be true that continence will lead to impotence. Such argument is utterly fallacious, as are most arguments from analogy. Facts in abundance prove the contrary. Common as is sexual vice, continence is not unknown among us, and the truth of our statement is not difficult to verify. The real argument from analogy is drawn from the breast. This gland is generally inactive for many years after puberty, and yet, whenever the call for its activity arrives, it is more or less perfectly responded to. As a matter of fact impotence does not depend upon the testicle, but upon the spinal cord; the sexual act is a physiological nerve storm, and not simply an act of secretion. Loss of sexual potency is due to some fault in the nerves of the parts, or more commonly in the centre in the spinal cord, which presides over this function. It is often a solitary nervous phenomenon, and by itself is not of grave import.

The third physiological fact we ought to teach is that no function of the body is so influenced and controlled by the higher nerve centres as the sexual. It is excited by lewd imaginings, loose talk and sensuous scenes. It is set in motion by even accidental stimulus of any part of the nervous system affected by the sexual orgasm. Hence the difficulty of continence. On all sides are sights and sounds that may become the stimulus of sexual excitement. The other side of the picture is equally true. By the exercise of watchfulness and self-control the occasions of such excitement may be reduced to a minimum and the passion may be subdued. Medical men are sometimes asked to formulate rules of diet and exercise—hygienic rules—by which immorality is to be banished. The task is altogether impracticable. Vice is voluntary, and it is only by the exercise of a resolute self-will that virtue is maintained.

We cannot but believe that were these three very elementary but fundamental physiological truths properly presented and enforced upon young men very much misery would be avoided. Ignorance of them drives men into the clutches of ruthless charlatans, leaves them a prey to groundless fears, and often leads them into vicious habits from which they are unable to free themselves. To withhold such knowledge is in many cases to leave youths in ignorance of the one power by which they can successfully contend against the evil. We feel strongly the urgent importance of this matter, and hence we speak plainly and hope that others, as they have opportunity, will do their best to help young men in their struggle against vice.

SIR HENRY THOMPSON'S letter to *The Times* has again drawn attention to a question of vital interest to the medical profession and the community at large. More than one recent case has served to point to defects in our system of death certification and registration. The most notorious was that of MATILDA CLOVER, whom NEILL poisoned with strychnine. It will be remembered that CLOVER'S death was registered and her body buried in the usual way on the strength of a certificate given by a medical man who had previously to her last illness been her professional adviser. It has been remarked that the miscarriage of justice, if it may be so termed, was due not to any inherent defect in the existing system of registration, but to a violation of the

duty imposed upon medical men in the matter of signing death certificates. Probably, but not certainly, an inquest would have been held in CLOVER'S case had a certificate not been forthcoming. We say probably because only one of two other events might have happened—either the coroner, on a report made to him, might have deemed the reasons for holding an inquest insufficient, or, failing a medical or coroner's certificate, the registrar might have recorded the death and issued an order for burial.

Against the possibility of registration under such circumstances it is clear that the strictest provisions should be made, and obviously the decision in any doubtful case ought only to rest with some person or persons well qualified to discharge such an important duty. A misrepresentation wilfully or carelessly made by a medical man might of course be undetected; but cannot we hope for a greater safeguard than at present obtains—namely, the fact that false certification is a punishable offence? We think so. If the registration of deaths was committed to the care of some specially qualified person, such official might be supplied with formulæ for interrogation, the use of which would enable him to detect an attempt to deceive or correct an error from inadvertence or carelessness. No doubt this would entail considerable additional expenditure, but it is a question whether the present complicated system of "civilisation," especially in our large towns, is not at once a demand and a justification for creating a system to obviate some of its attendant evils. Of this much we are certain, that registration of death should be prohibited until an inquest, or at least a post-mortem examination, has been made in every case where there is the merest suspicion of foul play or absence of all direct evidence of the demise. The increasing popularity of cremation carries with it the necessity that every possible precaution should be taken against the destruction of evidence which might lead to the detection of crime in particular and act as a deterrent to its commission in general.

Annotations.

"Ne quid nimis."

CHOLERA AND DESTITUTE ALIENS.

WE are again face to face with an immigration of aliens which is associated with danger to public health. Certain shipping companies have renewed the traffic of destitute Russian Jews between Hamburg and the port of London, and certain individuals at the East-end are doing what they can to induce the aliens to settle down in London and are supplying the immigrants with addresses to which they can say that they are going. Over one hundred aliens from Hamburg have thus entered London within the past fortnight, and inquiry as to their whereabouts after they have landed has shown that, as regards a substantial proportion of them, the addresses given were incorrect. Our system of cholera prevention is based on the assumption that sanitary authorities shall be informed by the port authorities of the localities to which persons arriving, either in infected ships or from infected ports, are going, this being necessary in order that such persons may be kept for a short time under observation. It was because this principle broke down under our original Cholera Order that a new one was issued by the Local Government Board, giving the port medical officer of health power to refuse to any person permission to leave the vessel unless that officer was satisfied as to the address given. It will be obvious, in view of the experience of the past few weeks, that the addresses now being provided for these aliens ought not to be regarded as satisfactory, and so long as such people come from infected ports it is earnestly to be hoped that port health officers will strictly fulfil the important duty which has been imposed on them. It is announced that Hamburg has for one or two days been free from cholera; but this does not mean that Hamburg is no longer an infected port. Indeed, the announcement comes together with a statement that a number of cases of cholera did not, after inquiry, turn out to be cholera of the severe sort that had hitherto prevailed. We do not know how far this statement was based on the result of bacteriological investigations, but we sincerely trust that the occurrence at the fag end of an epidemic of certain cholera attacks which are not bacteriologically on all fours with cases that were more typical during the height of the epidemic will not for one moment lead, on the part of our health authorities, to any relaxation in stringency as regards the interpretation of our Cholera Orders. Hamburg must for some time be a city which contains the cholera infection, and it must therefore be regarded as an infected place. And so long as this is the case people have no right to expect that they will be allowed to enter London with dummy addresses and then effectually to hide themselves from all further observation and control in the worst slums of our great city. We believe we are right in saying that Dr. Collingridge has, in view of what has transpired in this matter, determined on requiring a rigid compliance with the regulations, and we trust that no health officer of a port which is in communication with Hamburg or any other infected place will accept as satisfactory anything in the way of addresses unless the circumstances are such as really to "satisfy him." The time may not be distant when Hamburg must for public health purposes be, provisionally at least, regarded as no longer "a place infected with cholera." Then this immigration can no longer be prevented for the same reasons that have led to its discontinuance for several months past. But with this the health officer has no concern; he can only deal with the matter in so far as public health is concerned; and it will be for the State to decide whether, on other than health grounds, the growing immigration of destitute aliens into the metropolis ought to be controlled.

THE LORDS' COMMITTEE UPON METROPOLITAN HOSPITALS.

THE long-expected report of the Special Committee of the House of Lords upon the hospitals of the metropolis has now been made public, and attention will be directed with no small amount of interest to the conclusions which it embodies. It may be said at once that it does not point to legislation on any large scale. The Lords have come to the conclusion, fully justified and even necessitated both by the facts of the case and the evidence submitted to them, that the administration of the hospitals of the metropolis is too large and intricate a matter, and too well managed upon the whole as matters stand, to be with any public advantage taken over by the Government. Moreover the public interest, which is their main support, would not be increased, but diminished, if the State or a Government Department were interposed between the charity of the public and its objects. The proposal with which the report concludes concerning the appointment of a central board with general powers of supervision points to legislation. This proposal has been already considered in the columns of THE LANCET, and space does not serve for a reopening of the discussion to-day. This, together with some other points of interest in

the report, will be treated of in detail later on. At the present moment we desire to draw the attention of our readers to the document itself and the digest of it which appears upon another page, as a preparatory step to the fuller discussion upon which we propose to enter at a later date.

INTERNATIONAL MEDICAL CONGRESS, 1893.

AT the request of the President and general secretary Sir James Paget has undertaken the formation of an English committee to aid the executive of the Congress in such ways as may prove practicable. A preliminary meeting was held at 1, Harewood-place, on Friday, Oct. 28th, to which the following gentlemen were summoned: The Presidents of the Royal College of Physicians of London, of the Royal College of Surgeons of England, of the Medical and Chirurgical, Clinical, Pathological and Medical Societies, Sir Joseph Lister and Sir William MacCormac. Present—Sir J. Paget, in the chair; Sir Dyce Duckworth, Sir George Humphry, Mr. Hutchinson, Sir W. MacCormac and Mr. Makins, acting as secretary. It was decided to invite the presidents of public bodies and societies representing the various branches of medicine, together with representatives from the universities and provincial towns possessing medical schools, to form a committee. It was stated that Messrs. Cook would arrange for special transit of a party of not less than sixty members, could it be formed, and a letter was read from the general secretary, Professor Maragliano, to the effect that the French railway companies have agreed to give a reduction of 50 per cent. on all fares paid by members of the Congress travelling through France. The names of the members of the committee will be published shortly and a general meeting will be called. The committee will be glad later to give any information in its power to intending members of the Congress through its secretary. As already announced, the Congress will meet at the end of September, 1893.

AN UNSATISFACTORY CASE.

AN inquest was held on Oct. 4th by Mr. Hillman, coroner for East Sussex, touching the death of Jessie Nissen Shepherd, a widow, aged fifty years. The deceased had resided for some years at Hove. Mr. C. J. Smith, surgeon, identified the body. Mr. McNiece, of Carshalton, was her regular medical attendant. About twelve months since Mr. McNiece suspected aconite poisoning and broached the subject to his patient. During her fatal illness, which lasted three weeks, Mrs. Shepherd suffered from vomiting and other symptoms, which ended by death from convulsions. Again Mr. McNiece was suspicious that poison had been administered, and suggested to the certificated nurse on duty that it was arsenic. He directed her to search the house for poison. A bottle of white powder—afterwards proved to have been a cosmetic—was found. On grounds which, according to the finding of the coroner's jury, were insufficient Mr. McNiece went so far as to hint that a relative of the deceased might be the guilty person. Before Mrs. Shepherd died Mr. Smith and Dr. Uhthoff were consulted. These gentlemen came to the conclusion that the illness was due to Bright's disease and that the convulsions were of uræmic origin. Now, although Mr. McNiece had given utterance to his suspicions, he ultimately gave a certificate of death from uræmic poisoning. Very properly the relatives insisted on having a post-mortem examination, which was performed by Mr. Smith and Mr. H. H. Taylor. The left kidney was almost destroyed by obstructive dilatation. The right kidney was hypertrophied and pale on section, but the capsule was not adherent. There was an ovarian cyst containing three pints of purulent matter. The cyst had contracted and there were marked adhesions. There were no signs of irritant poisoning in the stomach or elsewhere. The powder before referred to, as well as portions of the viscera, were forwarded to Dr. Stevenson, the official analyst, in the event of further inquiry appearing necessary. Dr. Uhthoff, Mr. Smith and Mr. Taylor were unanimously of opinion that the symptoms and death were due to natural causes. The jury endorsed this view, and to their verdict added a rider that Mr. McNiece was deserving of severe censure in giving a certificate if he did not honestly believe that what he wrote thereon was true. No one could blame Mr. McNiece for entertaining a suspicion of poisoning, even though based on an error of judgment. The symptoms of irritant poisoning are simulated by several diseases of natural origin, as the annals of forensic history abundantly prove. At the same time we cannot altogether hold him blameless for his subsequent conduct. So long as there remained a shadow of doubt in his mind he ought not to have given a death certificate, and the report of the inquest apparently shows that he had not entirely abandoned the theory of poisoning. But having given the certificate it was his bounden duty to have at once acknowledged that he had made a mistake and to have unreservedly withdrawn the aspersions he had cast on the members of the family mentioned at the inquest, who, under the circumstances, are entitled to much sympathy. We do not presume to say that the evidence was not sufficient to warrant the verdict and the rider, but it would have been still more weighty had the result of an analysis by Dr. Stevenson been forthcoming.

VENTILATION AT THE LAW COURTS.

THE ventilation of the Royal Courts of Justice affords a perennial subject of comment from the judicial bench and in the press, but if Mr. Justice Day is correctly reported to have said a few days since that "the pumping engine was out of order, and could only pump the stale air used a couple of days ago," it may be hoped that he was dealing with a very exceptional state of things. The perverse ingenuity which could design plant for the storing up and preservation of stale air strikes us as being a nuisance so uncommon that it need not be seriously complained of; but even so we have a keen sympathy with the unfortunate people who are condemned to spend the day in one of the Courts at the Strand whilst the ventilating machinery is out of order. Whatever may be thought of some explanations of the phenomena which under these conditions obtain currency, the phenomena themselves are distressing in the extreme and in no mean degree unwholesome.

DIPHTHERIA IN SCHOOLS.

WE are glad to see that the prevalence of diphtheria in the Yerbury-road Schools, Holloway, has been brought under the notice of the London School Board, and that the fact is receiving a searching investigation at the hands of the medical officer of health, Mr. Harris. No less than thirty deaths have occurred of children in this school since October last. This is a most serious state of matters and one which demands the most complete inquiry, not only into the sanitary condition of the school, but with regard to the houses from which the children come. The parish of Islington has a reputation for good health, and had, until lately at least, a good record as respects diphtheria. But no general healthiness will avail if diphtheria finds favourable local circumstances and plentiful gatherings of young children, who are its chief victims. The valuable statistical tables of infectious disease which we publish monthly show that such a neighbourhood as Hampstead, with a small general mortality, may have in some months a large proportion of diphtheritic cases. General Maberley did not seem to relish the suggestion that the schools were to blame, and argued that the epidemic was prevalent in London, that only rain-water pipes went under the schools, and that the sanitary inspectors had made no inquiry into the

health of the habitations of the children. Mr. Harris has traversed all these statements and on the face of them they are of that vague kind with which officials are apt to deceive themselves, and convey no definite information and no suggestion for remedial measures. The very point of the question, as we understand it, is that there is a special incidence of diphtheria in these schools, or in the children that frequent them, as compared with other children in the same neighbourhood, perhaps in the same families, and with children attending other schools in the same parish. This localisation of the disease is sometimes intense and significant and it is only by studying closely instances in point that our knowledge of the origin and mode of communication of this disease can be increased. The medical officer of health of Islington will have the gratitude of the public in his endeavours to get at the bottom of this outbreak, and the members of the School Board should do everything in their power to assist his endeavours.

MOLESCHOTT'S JUBILEE.

THIS eminent biologist and teacher, whose scientific and professorial activity is still unimpaired, though he completed his seventieth year on August 8th last, will celebrate his jubilee in Rome on December 16th. The committee organised *ad hoc* have wisely chosen this latter month for the ceremony, as many of Moleschott's old pupils and colleagues might hesitate to visit Rome, even to commemorate his jubilee, in the late summer. This premised, it is safe to predict, a highly interesting and, historically speaking, a profoundly suggestive symposium in the capital of Italy seven weeks hence. Not only has the personal history of Moleschott been a most eventful one, but the revolutions in science and speculation he has witnessed are among the most momentous of the century now closing. A native of Bois-le-Duc, he naturally went to the University of Utrecht for his education, which, in its preliminary stage, was solid enough for the weighty professional superstructure he proceeded to build upon it. Choosing medicine as his *métier*, he became a pupil of Mulder, the great pioneer of physiological chemistry, and it was in Mulder's house that he formed the acquaintance of another Dutch physician not less illustrious than himself, the ophthalmologist Donders. This was in 1844, when the discoveries of Schleiden and Schwann were but six years old, when organic morphology was beginning to be transformed, and when only in 1842 had appeared the great work of Henle which impressed on the revolution they had effected the character of a comprehensive and fruitful reformation. "Schwann and Henle," says Moleschott himself, "in examining the chemical nature of the tissues knew no means beyond acetic acid and water," and he recalls the sceptical look of Henle when in 1844 he told him that Mulder and Donders had determined on delivering their histological attack with potash and sulphuric acid. Engaged for a brief space in private practice, Moleschott continued his laboratory work under Mulder, till in 1847 he was called to Heidelberg, where till 1854 he acted as *privat-docent* in physiology in its widest and most penetrating acceptation. Then it was that his powers as an investigator and expositor, not only in his prælections, but in his "Physiologie der Nahrungsmittel," his "Physiologie des Stoffwechsels," and his "Lehre der Nahrungsmittel," drew the attention of the scientific world by their bold and trenchant criticism of orthodox chemistry and physiology. Liebig was the main object of his attack, and when he demonstrated many of the great man's positions to be quite untenable and even mischievous to science he incurred displeasure in high quarters, and received a very broad hint that persistence in his polemics would be followed by the withdrawal of his permission to teach in public. He then quietly withdrew to Switzerland, not, however, before bequeathing to Germany a controversy which did not cease till Liebig's too despotic authority had been reduced to juster and sounder limits. In Zurich he more than maintained the high reputation he brought from Heidelberg, and it was while there in 1861 that, in compliance with an old-standing invitation from Cavour, he left for Turin to undertake the duties of the physiological chair. His success was speedily apparent, and in turning out such pupils as Mosso and Bizzozero he soon showed of what immense value was his influence in the subalpine school and how amply Cavour's sagacity was justified in forcing "this *novus homo*" on Piedmontese science. Shortly after Rome became the capital of United Italy Moleschott was called to the chair of Physiology in the Sapienza, and there again he has outlived the prejudices that always beset a foreigner and outsider even in the domain of science, till in the ever-widening circle of distinguished and devoted pupils he has now a phalanx of admirers and vindicators that render him proof against all local attack or Chauvinistic disparagement. Indeed, the promoters of the imminent celebration of his jubilee whose names occur in the list now before us are, many of them, not only Italians but Romans, who as colleagues or contemporaries or pupils have learned to appreciate his work and to honour the worker. No one, indeed, at all familiar with Italian medical teaching as it was twenty-five years ago can fail to understand the wholesome, the reinvigorating influence of this Teutonic importation into a Latin atmosphere. His thoroughness, his philosophic breadth of view, his conscientious exhaustion of detail before proceeding to generalisation—all these were lessons greatly wanted by the Italians, who were perpetuating the effete traditions of the early decades of the century. Nor was Moleschott wanting in those literary graces and accomplishments in which his predecessors, whether in Turin or Rome, preponderated. Like his friend and fellow-student Donders, an accomplished classical scholar and linguist, he endeared himself to the Italians by a proficiency in Dante and a power of quoting him opportunely and with an effect not often shared by the mighty Florentine's compatriots. Year by year his hold on young Italy has deepened and strengthened; he has won their admiration by his learning and expository power and their love by his devotion to the Italian cause and his sympathy with its healthy and steady evolution, while at the same time he has retained the esteem of his academical and professional colleagues by a geniality of disposition and a suavity of address not always associated with Teutonic antecedents. All these elements of popularity and influence combine to ensure for his approaching jubilee a success honourable alike to its promoters and to its hero, and we shall watch with no common interest the commemoration of a career which, begun in Utrecht, continued in Heidelberg and Zurich, transferred to Turin, and culminating in Rome, has, at every stage, been coincident with the advancement of biological research and with the strengthening of the bases of scientific medicine.

PHARMACOPŒIAL SYNONYMS.

THE arguments in favour of extending the list of pharmacopœial synonyms have frequently been brought under the notice of the General Medical Council by Professor Attfield, and much has been done in this direction towards ensuring uniformity in the composition of substances which are frequently sold under popular names. Uniformity of composition is indeed the only safeguard against serious misadventures. Nothing can be more dangerous than the sale of drugs by the same name, where the ingredients differ, especially if in one case the preparation has been "improved" by the entire omission of the principal active ingredient. Sick persons may take this compound in increasing doses with impunity and thus incur very serious risks if on any occasion

they are elsewhere supplied with a specimen which has not been "improved." Those responsible for changes in the Pharmacopœia are fully alive to these risks, but that their work has not yet been generally appreciated or even recognised is obvious from the recent proceedings at the North London Police-court. A herbalist was summoned under the Food and Drugs Act for "selling a substance called paregoric which was not of the nature and substance demanded by the purchaser." Possibly it was originally intended to prosecute for the unlicensed sale of a drug containing opium, but no opium was found in this substance, and the prosecution under the Food and Drugs Act should have held good, if it could have been proved that the legal composition of paregoric had been defined by the admission of this name in the Pharmacopœia as a synonym for tinctura camphoræ composita. The counsel who defended maintained that "there was no substance called paregoric in the British Pharmacopœia, either of 1885 or in the edition of 1889," and, in the absence of rebutting evidence, the case was dismissed. Professor Attfield, the annual reporter on the Pharmacopœia to the Medical Council, whose painstaking work has so often been favourably noted in the columns of THE LANCET, may well feel aggrieved that this evidence was not forthcoming, since, as he explains in a letter to *The Times*, paregoric was inserted in the third reprint of the British Pharmacopœia in November, 1888, and in the gratis list of corrections issued in the same month as well as in the fourth and fifth reprints. Special attention was drawn to this insertion in the prefatory notice to the reprint of 1888; hence the omission of evidence to this effect at the time the case was heard must remain a mystery.

PETITION TO THE MEDICAL COUNCIL *IN RE* MEDICAL AID ASSOCIATIONS.

WE are asked to say that the following petition has been prepared, at the instance of the Medical Defence Association, for presentation to the General Medical Council at its approaching meeting on Nov. 22nd. Any registered medical practitioner approving it and wishing to add his name is requested to address a card to Mr. Ernest Hugh Fitzpatrick, L.R.C.P. Edin. &c., 122, Moseley-road, Birmingham, with the authority to add the name (which should be given in full, with qualification and address) to the petition. The petition reads as follows:—"To the president and members of the General Council of Medical Education &c. This petition of us, the undersigned duly registered medical practitioners, showeth—that the modern system of medical practice conducted by the ostensibly philanthropic institution designated 'Medical Aid Association,' and similar bodies, is degrading to the profession and injurious to the public. And your memorialists pray that your honourable Council will take this increasingly important question into your consideration, and take such steps as may appear necessary in order to bring about an amendment of the evil.

SERVANTS' ACCOMMODATION.

IT would be folly to think of obliterating entirely the distinctions of privilege which belong to the position of a master or a mistress, and certain social amenities may reasonably be allowed to the latter which are not equally accessible to their domestics. In making this admission, however, it must be remembered that it is true only with limitations. It applies to many matters of dispensable comfort. It does not apply to participation in the absolute necessaries of life. It cannot be used as a sanction for indecent and unwholesome herding underground such as occurred in a case lately reported by Mr. Wynter Blyth, in which three domestic servants were literally stowed away overnight in mere cellars, under stairways—damp, sunless and unventilated. Such wretched accommodation, it is to be hoped, does not often fall to the lot of young persons in service, and no one could, with any pretence of logic, dispute the justice of serving their employers with the vestry order issued in this instance. It is certain, notwithstanding, that in this very matter of house-room custom leaves much to be desired. The term "servants' accommodation" does not necessarily indicate a fixed measurement of even 600 cubic feet, the minimum compatible with healthy conditions, for each person. Ventilation and cleanliness are usually but little considered, though the blame for such neglect must be shared by the servants themselves. The resulting consequences upon health are matters of daily observation. It is therefore clearly to the advantage of householders to see to it that the domestic reforms called for in the circumstances are carried out. Failing such action on their part, there appears to be no alternative but the far greater inconvenience entailed by official interference.

ISOLATION ARRANGEMENTS AT PLYMOUTH.

A GOOD deal of discussion is going on at Plymouth with reference to the question of isolation hospital provision, the immediate cause of the discussion being the inability of the Town Council to isolate a case of scarlet fever when such isolation was first needed. The rights and wrongs of the individual case are unimportant compared with the fact that the Corporation of Plymouth have for so many years delayed the provision of adequate accommodation for the important town for which they are responsible, the delay having taken place under the shelter of various pleas, including the refusal of the Local Government Board to approve of a loan to carry out a scheme which, in their opinion, seems to have involved failure. At last this difficulty has been removed by the preparation of new plans which have been submitted for approval and which it is anticipated will meet with the necessary consent. It is much to be hoped that no needless delay will be allowed to arise on the part of either the central or the local authority, for the absence of adequate means for isolating cases of infectious fever in Plymouth has long been a reproach to that borough.

THE LESSONS OF THE ALPINE SEASON.

A SAD interest attaches to the statement, lately published in the daily press, that the whole number of fatal mountaineering accidents in Europe during the present year amounts to thirty-two. This total perhaps is not very great when we compare with it the number of those who have employed the past season in Alpine climbing or the risks which they must necessarily incur. When, however, we learn that the unfortunate persons who thus lost their lives were in twenty-six cases unattended by any guides whatever, the tribute thus exacted of healthy recreation must appear unduly large. Suspicions of rashness and incompetence will not be set aside. It is true that all climbers are not rash, nor all routes hazardous; but it can hardly be disputed, in the face of such facts as those above stated, that skilled instruction and assistance are still too little utilised. Without such aid there must be an inevitable tendency to misunderstand conditions of weather, season and ground, which are, especially to the tyro, matters of the gravest moment. The ambition to scale a great peak offers to such especially a dangerous attraction, and it is characteristic of the humility of experience that more mature men prefer to begin a season with one or two easy ascents. Physical capability is a question for individual and very careful consideration. Almost anyone may visit Switzerland, but it by no means follows that anyone may risk the effort and exposure of a day, or perhaps two days spent in ascending a peak. The calamity which overtook the late Professor Nettleship and his party affords a melancholy example of the uncer-

tainties attending even a comparatively ordinary effort in mountain climbing and the endurance which it may entail. Such considerations ought to teach the unwisdom of hasty action in matters of this kind, and, above all, the fact that self-reliance with inadequate knowledge is no better than foolhardiness.

MEETING OF THE GENERAL MEDICAL COUNCIL.

THE General Medical Council will meet on Tuesday, Nov. 22nd, at two o'clock. It is impossible not to see that the action and functions of the Council are becoming more and more matters of public interest. And many considerations lead to the conclusion that at the approaching meeting the Council will have to deal with difficult questions respecting not only the professional conduct of registered practitioners, but concerning the safety and welfare of the public. We may take an opportunity before the meeting of the Council of considering the form in which these questions are likely to arise, though in the absence of the programme of business we can only conjecture.

RAG IMPORTATION.

ALREADY the effect of the various rag orders which have been drawn up by the Government as precautionary measures against cholera is being felt in the heavy woollen district. It is reported that manufacturers have been obliged to withdraw from their patterns all goods made from foreign rags, and that for certain classes of goods particular rags (now prohibited) are exclusively required. A request has been made by northern Chambers of Commerce that the Local Government Board should permit the landing of properly disinfected or carbonised rags, and that the prohibition of rags from France, Holland, Belgium, and States of Germany, unconnected with Hamburg, should cease in November. These are far-reaching requests which will doubtless be duly considered by the Government. But no selfish local commercial interests should be allowed to intervene between the public duty of the Government and the general interests of the population of this country that would be likely to suffer from an importation of cholera.

SCARLET FEVER IN BOARD SCHOOL CHILDREN.

THE old story of a coach-and-four being driven through any Act of Parliament finds its latest illustration in the easy evasion by parents of the Notification Act and the efficacy of the simple plea of ignorance. Three parents have been summoned before the magistrate of the South-Western police-court for exposing their children while suffering from scarlet fever and also for neglecting to notify. None of the children had medical attendance, and the excuse of the parents was that they did not know their children were suffering from scarlet fever. Dr. Little, chairman of the sanitary committee of the local board, gave evidence, and said the symptoms were unmistakable. Cases multiplied in the neighbourhood and suspicion fell on the local Board school. The mistress of the school sent to the sanitary inspector, expressing her belief that one of the children in the school had scarlet fever. Both the inspector and Dr. Little went to the school and found there were no less than three cases in a state of active and obvious peeling. Two of the children had gone continuously to school, the third had been kept at home on account of "a sore-throat and cold." Dr. Little has kindly given us further particulars in a letter. The schools have been closed. Between thirty and forty cases have occurred, and hospital accommodation has had to be supplied. The cost to the ratepayers is estimated to be between £300 and £400. The magistrate (Mr. Denman) expressed an important opinion. Dr. Little had given evidence that he could not say that he believed that the Parents knew their children had scarlet fever; but he thought they had shown great carelessness, as there must have been a rash and the desquamation was very noticeable. Mr. Denman said he would like to see an Act passed making parents responsible whether they had a guilty knowledge or not. This is what it must come to. The sense of responsibility in parents whose children are suffering from diseases so mischievous to others must be quickened. There is no excuse in these days for parents who neglect their duty in this respect when medical advice can be so easily procured.

THE FOUNDLING HOSPITAL.

THE secretary of this hospital reports that the outbreak of scarlet fever there has not been virulent, but proceeds to state that since last March 200 children have suffered from the disease. This seems a large number, and points strongly to the need of some isolation building. The secretary states, too, that the drainage was remodelled in 1886, and has been recently pronounced satisfactory by Dr. Sykes, the health officer of St. Pancras. The latter writes to *The Times* to correct this rosy view, and to state that he had reported that the grease trap required alteration, that all waste-pipes should be cut off from the drains and sinks removed from wards and dormitories. He had also strongly advised that an isolated infirmary and probationary ward should be constructed. We trust, with Dr. Sykes, that the committee of this excellent institution has seen fit to carry out the above suggestions, and that there will be no recurrence of scarlet fever, which has excited so much comment.

THE STOURPORT MEDICAL AID ASSOCIATION.

A CORRESPONDENT dating from Aston, writing to the *Birmingham Daily News*, says that in the Stourport Medical Aid Company there are, or have been, all the Dissenting ministers, one solicitor, four members of the local board, nine-tenths of the publicans, 50 per cent. of all the tradesmen (including large drapery houses), all the coal merchants, many owners of house property and a large number of farmers. The surgeon receives less than 1*s.* 11*d.* per member. He is said to be no better off with a membership of 3058 than when there was only a membership of 2000. It is lamentable that respectable and intelligent men should continue in associations so to "sweat" and to starve a liberal profession. We cannot pretend to see what advantage they gain by it or hope to gain. There is no compulsion in them so to act. They cannot maintain that there is any justice or adequacy in such terms. It is of course lamentable that medical men so poor either in spirit or purse should be found to take such appointments, to the ruin of their profession. But this does not acquit ministers of religion, publicans and thriving tradesmen.

THE POLLUTION OF THE AIRE.

IT is well known that the West Riding County Council have for some time past been desirous of putting an end to the disgraceful and well-nigh intolerable state of the river Aire, which is fouled to an almost incredible extent with sewage and trade refuse. With a view to this end a conference was organised at Leeds last week between the Sanitary Committee of the County Council and representatives of the sanitary and conservancy authorities in the basin of the Aire and its tributaries. There seemed to be a unanimity of opinion that the sewage pollutions ought to be forthwith dealt with, and that as regards trade refuse steps ought at once to be taken to ascertain how this may best be treated or disposed of so as to avoid pollution of the river. Notwithstanding the apparent concurrence of opinion, we almost fear that nothing very immediate is in prospect. Leeds and Bradford claim that since they are county boroughs they are not concerned with any

conclusions at which the County Council may arrive; trade interests have probably influenced the decision that the sewage difficulty should be first disposed of; and even the most successful of all means for delay—namely, a Royal Commission—has been suggested in a resolution. The alternative of a Conservancy Board with adequate powers seems to offer a far more reasonable chance of successful and fairly prompt action, and we trust that due consideration will be given to this alternative. Under any circumstances, the West Riding County Council deserve credit for the action they are taking, and it is to be hoped that they will receive local and imperial help in prosecuting the task they have undertaken.

BAD MEAT AT PRESTON.

IT is alleged that this town has been used as a depôt for diseased meat. This state of things too has, it is said, been allowed to grow up in spite of, and indeed with, the connivance of certain officials. It was stated that a considerable trade in distinctly bad meat had taken place in Preston, and one member of the Town Council connects the abnormally high death-rate of Preston with the above-mentioned fact.

REMOVAL OF TUMOUR FROM THE SPINAL CANAL.

LAST week, in King's College Hospital, Mr. Watson Cheyne removed from a patient a large myxomatous tumour, which was situated in the spinal canal at a portion corresponding with the lower part of the dorsal and the upper lumbar regions. The nature of the tumour and its exact position had been accurately diagnosed by Dr. Ferrier. The growth was encapsuled and was easily removed. Unfortunately, the patient died thirty-six hours after the operation.

DEATH FROM GODFREY'S CORDIAL.

THE Borough Coroner of Leeds lately held an inquest on a child six days old which had died from an administration of Godfrey's Cordial by its mother as it seemed to be in pain. Mr. Hawkyard, a surgeon, said he found it collapsed and blue. He said the preparation contained opium and was not fit to be administered to so young a child. Of course this is so. We do not blame the mother so much as the state of the law which permits the sale of such poisons by chemists.

SMALL-POX OCCURRENCES.

AMONGST the places in which small-pox is either prevalent or new attacks are occurring are Halifax and its vicinity, Stamford, Stockbridge, Warrington, where the outbreak is a serious one, Hipperholme, Wyke near Bradford, Melton, where it has appeared in the workhouse; Scarborough, Daventry, Higham-Ferrers and Leicester, where three cases have quite recently occurred.

NEW PRODUCTION OF BLEACHING POWDER.

THE researches of Mr. Ludwig Mond have again been rewarded with commercial success. Some two years ago the chemical world was startled by Mr. Mond's discovery of the remarkable and unexpected carbonyl series, and now it appears he has succeeded in recovering the chlorine from the alkali waste in the Solvay or ammonia-soda process. It will be remembered that in the manufacture of soda by this process common salt is treated with ammonium bicarbonate, sodium bicarbonate and ammonium chloride being formed by double decomposition. The bicarbonate of soda is either crystallised out as such or subjected to heat with conversion into normal carbonate. The by-product, ammonium chloride, to which this new discovery relates, was previously heated with lime to recover the ammonia, the calcium chloride being thrown away, but it would seem now that the chlorine itself can be saved. The ammonium chloride is crystallised out, dried, volatilised and passed over oxide of magnesia, so disposed as to present a large surface; the chlorine goes to the magnesium, the oxygen of which forms water with the hydrogen of the chloride, and ammonia is carried forward in the free state. The reverse process is now instituted, but air is passed over the magnesium chloride, which is reconverted into oxide, and the chlorine is used for the production of bleaching powder. The process is said to be actually at work on the large scale, so that the questions of cost and fuel consumption have no doubt been satisfactorily solved.

FOREIGN UNIVERSITY INTELLIGENCE.

Basle.—Dr. A. Jacquet, Assistant in the Medical Clinic, has been recognised as *privat-docent* in Experimental Pathology and in Pharmacology.

Brussels.—Dr. Warnots has been appointed Professor of Operative Medicine in succession to Dr. Tirifahy, who has resigned.

Cracow.—Dr. Braun has been recognised as *privat-docent* in Midwifery and Gynæcology.

Dorpat.—Dr. A. S. Budilovich of Warsaw has been appointed Rector, in succession to Dr. Meikoff, whose health has obliged him to resign.

Gratz.—Dr. Zoth has been recognised as *privat-docent* in Physiology.

Jena.—Dr. Ludolf Krehl of Leipsic has been appointed Professor and Director of the Medical Policlinic. Dr. Wagenmann of Heidelberg has been offered an Extraordinary Professorship of Ophthalmology, with the charge of the eye clinic.

Lausanne.—Dr. Eugène de la Harpe has been recognised as *privat-docent* in Climatology and Balneology. Dr. Paul Demiéville has been appointed Extraordinary Professor in the Policlinic.

Prague (*German University*).—Dr. Edmund Münzer has been recognised as *privat-docent* in Special Pathology and Therapeutics.

St. Petersburg (*Military Medical Academy*).—The contest for the chair of Special Pathology and Therapeutics lately vacated by Professor Manassein, editor of the *Vrach*, has been unusually severe. The result is that the Professorial Conference has by a considerable majority selected Dr. Nilus Sokoloff.

THE Regius Professor of Medicine of Oxford University has given notice that the examination in Human Anatomy and Human Physiology at the first examination for the degree of Bachelor of Medicine will commence on Wednesday, Dec. 7th, at 10 A.M., in the University Museum. In consequence of a recent change of statute it is no longer necessary to forward any certificates or testamurs.

ON Thursday, Oct. 27th, at a special meeting of the Council of Epsom College, the following resolution was unanimously adopted: "That the report of the school committee (which we print on page 1067) on the dietary at the College be received, adopted and its recommendations carried into effect; and that copies be forwarded to the parents of all boys at the College and to the leading medical journals."

DR. DAVID CALDWELL M'VAIL of Glasgow has been appointed Crown representative for Scotland on the General Medical Council, in lieu of the late Sir G. H. B. MacLeod. Dr. M'Vail has already been a member of the Council as representative of the faculty of Physicians and Surgeons of Glasgow from June 7th, 1886, to April, 1888, when he was succeeded by Dr. Hector Cameron.

AT the autumn general meeting of the Governors of St. Mungo's College held on Oct. 27th, the Professor of Systematic Surgery, Mr. David N. Knox, M.A., M.B., was appointed Professor of Clinical Surgery in room of Professor William Macewen, LL.D., who had resigned in consequence of his appointment as Professor of Surgery in Glasgow University; and Mr. Henry E. Clark, M.R.C.S., Professor of Anatomy and Dean of the Faculty of Medicine, was appointed Professor of Systematic Surgery, vice Professor Knox. Applications for the chair of Anatomy should be lodged with the Secretary on or before Dec. 1st next.

OWING to the death of Lord Sherbrooke a vacancy has occurred in the Senate of the University of London, and in accordance with precedent his place will be filled by a graduate in science or medicine. Dr. W. J. Collins, M.S., B.Sc., F.R.C.S., is a candidate, and probably other names will shortly be announced.

THE next meeting of the Odontological Society of Great Britain will take place on Nov. 7th, when Mr. Storer Bennett will read a paper on Some Mechanical Devices for the Retention of Artificial Dentures, and a communication will be given by Mr. F. Newland-Pedley on Inverted Lower Canine Tooth erupting below the Chin.

THE Royal Commission on Vaccination held another meeting on Wednesday last, Sir James Paget presiding. Dr. J. C. M'Vail was examined and gave evidence in favour of vaccination. The Commission then adjourned until Wednesday next.

THE Royal Medical Benevolent College has received a donation of £1000 from a friend who does not wish his name to be known.

PROFESSOR VIRCHOW has been appointed an honorary member of the Imperial Russian Natural Philosophy Society.

HOSPITAL FEDERATION IN LONDON FOR CLINICAL PURPOSES.

BY JOHN ERIC ERICHSEN, LL.D., F.R.S., F.R.C.S. &c.

IN the Report of the Royal Commission on a Teaching University in and for London it is stated that the opportunities for clinical instruction that exist in the metropolis are "unrivalled." That this is so admits of no doubt, and that these unrivalled opportunities are not utilised to anything like their full extent is equally certain. No evidence was given before that Commission to show how these admittedly unrivalled opportunities could be utilised with more advantage to the student than they now are, and the report is silent on this most important point. I trust that I may therefore be excused for venturing to make some suggestions towards the attainment of so desirable an end. I have visited at various times most of the great medical schools in Europe and in the United States of America, and I can without hesitation affirm that the word "unrivalled," used in the Report of the Royal Commission as descriptive of the clinical opportunities presented by London, is the correct designation. No city in the civilised world offers such a wealth and so varied an abundance of clinical material as does London, both as regards general medical and surgical practice and particular forms of special disease, and yet so little are these unequalled opportunities utilised that English medical students annually resort in large numbers to the cliniques of Paris, Vienna and Berlin in order to obtain that professional knowledge to which access is denied them in this metropolis. They can there follow without restraint and at little or no cost the teaching of the most eminent physicians and surgeons and of the most able specialists of the day. They return skilled in foreign methods of diagnosis and of treatment, but with little knowledge of those that are to be learnt in this great city, outside the walls of the particular hospital in which they have been educated; for to the vast and varied stores of clinical information that here lie within easy reach access is practically denied, and indeed of their very existence they may be ignorant. The student is obliged to go abroad for the purpose of obtaining advanced and special clinical instruction, not from any lack of material here, but in consequence of its inaccessibility and the absence of all proper organisation for its study and utilisation. In London he is absolutely restricted to the teaching of the physicians and surgeons of the one particular hospital to which, as a pupil, he has attached himself and for which he has paid his fees. The invaluable instruction to be gained from the vast practical experience and profound scientific attainments of such teachers as a Jenner or a Gull, a Paget or a Lister, or the skill to be acquired by being the daily witness of the consummate methods of a Liston, a Fergusson, or a Bowman, are denied him here unless he happens to have entered as a pupil to the hospital to which one or other of these masters of their science and art is at the time attached. To the practice of that one particular man he is admitted. From that of the others he is shut out, unless he possesses the means and has the inclination to pay a second or a third time the very considerable fee for "hospital attendance." This, indeed, is a student's question, and the matter should be considered from a student's point of view rather than from that of the teacher in the medical school or the governor of the hospital. The London student has a right to expect that he shall not be placed at a disadvantage by the refusal freely to open to him those vast stores of clinical observation and study that are to be found in such unequalled and profuse abundance in London, and thus to be compelled either to starve his craving for knowledge if he remains here or to satisfy it at the cost of going abroad. There is no other alternative. But may not this state of things, so injurious to the best interests of medical education, be corrected? Is it not possible to place London not only on a level with but far ahead of all other European capitals, as a great school of clinical medicine and surgery in the widest sense of clinical teaching as well as in its more special departments? I cannot doubt that with proper organisation of the enormous opportunities for clinical study that exist in London, and by rendering these accessible to the advanced student and young practitioner, the necessity for foreign study will no longer be felt, and that the cliniques of London will attract in their turn students not only from all parts of the United Kingdom, but from our colonies, the United States of America and even the Continent of Europe. Those who may wish for special opportunities of study and of instruction in every department of clinical medicine and surgery will come here, and the cliniques of London will be placed in that pre-eminent position which their physicians and surgeons have so long and so ably maintained. The value of a clinique is determined by three considerations. These are: first, the amount of clinical material; second, the character of the cases; and third, the ability of the teachers. Few, even amongst the members of the medical profession, are probably aware of the immense amount of clinical material that exists in London. The vast number of diseased and injured persons of the class that seeks cure and relief in our hospitals, infirmaries and medical charities of all kinds far exceeds that of any other city in the world. The population of the county of the city of London equals in numbers that of the whole of Scotland and exceeds greatly that of many continental Sovereign States. Engaged in every possible kind of industrial pursuit hazardous to life or limb, and injurious in many special ways to health, it would of necessity furnish an enormous amount of injury and disease. To this must be added a very large number of persons suffering from serious or special forms of disease who are constantly attracted to London from all parts of England, and even from the colonies, by the world-wide reputation of its hospitals, both general and special, and by that of individual members of their staffs.

There are eleven general hospitals in London of sufficient size to be recognised by the Royal Colleges as schools of clinical medicine and surgery. In these eleven clinical hospitals there is a total of 4542 beds.[1] The number of beds varies greatly, from 750 in the largest to 180 in the smallest of these hospitals. Besides these there are several smaller general hospitals, such as the Great Northern, the Metropolitan, the West

[1] This number is taken from the list published in the British Medical Journal for Sept. 3rd, 1892.

London and the North-Western Hospitals, which, although not recognised by the Examining and Licensing Corporations as schools of medicine, afford abundant opportunities for clinical study and the acquirement of practical experience. The amount of clinical work done at a hospital cannot be measured solely by the number of its beds. The out-patient departments which have now grown to enormous and almost overwhelming proportions in all the London hospitals furnish an abundant supply of interesting and instructive cases, more particularly of various special forms of medical and surgical disease which do not require to be treated in hospital—such as affections of the eye, the ear, the skin and the throat—for which special cliniques are now established in all the larger general hospitals. In addition to these there are special departments in the general hospitals for the treatment of diseases of women and children, and to all a maternity charity is also attached. The Poor-law infirmaries in the metropolitan area are very numerous and contain a vast number of beds. I find on reference to Churchill's Medical Directory for 1892, the most reliable source of information on such a subject, that there are no less than twenty-seven such infirmaries, containing an aggregate of 13,285 beds, or an average of nearly 500 beds. These are, in fact, general hospitals, and contain an immense amount of clinical material that now goes to waste, but that admits of being most advantageously utilised. Of its great value I can give no better proof than that of the work done by Sir Henry Thompson, who, when surgeon to the St. Marylebone Infirmary at the commencement of his brilliant career, made there a series of researches on the Diseases of the Prostate of the most important character; whilst his predecessor, Mr. Benjamin Phillips, F.R.S., found in the wards of the same infirmary the material which served as the basis of his work on Scrofula. These infirmaries contain inexhaustible material for the study of the diseases of advanced life, of childhood and of many special forms of disease, such as those of the skin. In early professional life I was a frequent visitor to the wards of the St. Marylebone Infirmary, which was then officered by Dr. Mayo, President of the Royal College of Physicians, Dr. Glendinning and Mr. Benjamin Phillips, F.R.S., and learnt much in them of diseases that are not usually met with in general hospitals. The special hospitals of London are very numerous. They are of two kinds: those that have been established by the benevolent public to fill a gap and a recognised want in the other charitable institutions, and those that have been founded by and, to use an American expression, are "run" by special practitioners. For obvious reasons such institutions as the latter are not suited for educational purposes or as schools for clinical instruction. But the special hospitals that belong to the first category are numerous, large, well equipped and officered by physicians and surgeons of the highest eminence and of acknowledged ability in their respective special lines of practice.

It would be impossible here to mention all the special hospitals that exist in London and might be made available for clinical instruction. But a few of the most important may be specified. Thus the seven "fever" hospitals for the reception of acute zymotic diseases contain (1892) a total of 2571 beds, often greatly augmented in periods of the prevalence of epidemics, as of typhoid or scarlet fever.[2] The two largest hospitals for diseases of the chest—viz., the Brompton Hospital for Consumption and the City of London Hospital—contain respectively 321 and 164 beds. The Moorfields Ophthalmic Hospital contains 100 beds, but as the vast majority of cases of eye disease admit of being treated as out-patients, it is in its external clinique rather than in its in-patients that the measure of its utility as a clinical school is to be found. The Cancer Hospital contains 120 beds and the Lock Hospital 155. Both these institutions contain valuable material for clinical study. There are at least eight special hospitals for children, containing an aggregate of 621 beds. Of these eight hospitals, two—viz., the hospital in Great Ormond-street, with 175 beds, and the East London Hospital, with 102—would be available for purposes of clinical instruction. There are five hospitals for diseases peculiar to women, containing an aggregate of 241 beds, which are chiefly devoted to the reception of patients suffering from diseases requiring surgical treatment. In addition to these there are eight lying-in hospitals. The National Hospital for the Paralysed and Epileptic, in Queen-square, contains 175 beds, and is now thoroughly equipped for clinical instruction. There is one special hospital which I believe to be peculiar to London—I mean the Poplar Hospital for Accidents, an institution rendered necessary by the hazardous work carried on in its neighbourhood. It contains 51 beds. There is thus in the general and special hospitals alone an aggregate of from 8000 to 9000 beds available for clinical purposes. The asylums for idiots, imbeciles and lunatics are very large. The five asylums for idiots and imbeciles contain an aggregate of 6750 beds. Bethlem and St. Luke's Hospitals contain a total of over 500 beds, and the five public lunatic asylums specially connected with the metropolis have an aggregate of 12,705 beds.

In addition to the vast amount of clinical material that exists in London in its various large general hospitals, its infirmaries, its more important special hospitals, its maternities and its asylums for the idiotic and insane, and which might all be made available for the purposes of study and of instruction, there is much more to be found in the smaller hospitals and in the dispensaries which abound in the metropolis. These institutions, though highly useful for the purposes of private study and observation, are neither officered nor equipped in a manner that would render them available as clinical schools. They have accordingly been left entirely out of present consideration. It is not only the amount of the material available for clinical instruction that has to be taken into consideration in estimating the value of a clinique; its character must also be taken into account, and in this respect London will be found to be as far beyond all rivals as in the mere number of its patients. By the character of the clinical material I mean the importance of the cases of which it is composed, either as regards severity or rarity, or as presenting typical forms of disease. The high reputation of the metropolitan hospitals and the acknowledged eminence of many members of their staffs have always attracted a large number of persons suffering from the more serious, special or incurable forms of medical and surgical disease to seek advice in the metropolis. This number has been largely increased of later years by the facility and cheapness of transit. Many provincial practitioners also prefer to send their more important cases for advice and operation to their old hospital and their old teachers in London, on whose judgment and skill they have reliance and with whose views they are acquainted. A considerable percentage of the in-patients in the London hospitals thus comes up to London for advice and operation. I find that at University College Hospital—with the details of which in this respect I am only acquainted—the proportion of the in-patients who come or are sent up from the provinces amounts as nearly as possible to 10 per cent. of the whole. But there is another potent factor in raising the standard of gravity in the in-patients of many at least of the London hospitals. It is their acknowledged insufficiency in point of accommodation for all of those who seek their aid. Hence a strict process of selection is adopted by the resident officers in the admission of patients, and only the most severe, urgent and important cases are admitted, all of those who can in any way be treated in the out-patient department and most of the chronic cases being referred to it.

Of the professional eminence and the special aptitude for teaching of the large body of distinguished physicians and surgeons connected with the London medical schools I need say nothing, as they are universally recognised and are beyond dispute. There is thus every element for the formation in London of the most important school of clinical medicine and surgery in the world. But to do this the material at hand must be organised and rendered accessible to the student. We will now consider how this can be done. The available clinical material that exists in London may be arranged in three groups of institutions—viz., the general hospitals, with medical schools attached, the larger and more important special hospitals, and the poor-law infirmaries and asylums. Of these, the eleven large general hospitals with their 4542 beds, their special departments and their maternities are by far the most important. They are the most important not only on account of the number of beds they contain and the character of the cases that fill those beds, but of the acknowledged eminence as practitioners and teachers of the great body of physicians and surgeons attached to them. Taken collectively and federated together, so that the instruction given in them should be opened to the advanced student, they would constitute a great clinical school of medicine and of surgery in all their branches that would be without an

[2] At the present time (October, 1892) these hospitals contain over 4000 cases of scarlet fever, diphtheria and typhoid fever.

equal in Europe. In this case union is strength. Taken collectively they are superior to all. But their weakness lies in their isolation, for, taken singly as separate and distinct clinical schools, many of them are inferior as regards number of beds, construction and equipment to some of the great provincial hospitals in this country, and none, not even the largest and most important, can claim superiority as clinical schools over those of the capitals and great cities of the continent of Europe or in the United States of America. The remedy is to be found in the abandonment of the system of isolation that at present exists, and which neutralises the immense and undoubtedly unrivalled opportunities for clinical study that are to be found in the great hospitals and other medical charities of London. For this should be substituted a system of federation for clinical purposes. For it is idle to speak of these opportunities as being "unrivalled" so long as the most important of them are cut up into as many distinct and separate fragments as there are hospital schools in the metropolis, and the remainder are scarcely, if at all, utilised; so that for all purposes of clinical instruction each hospital school is as completely separated from its neighbour as if it were at the Land's End or at John o' Groats house. Unless a system of federation for clinical purposes be substituted for that of isolation and the unrivalled opportunities that I have shown to exist be fully utilised so as to be brought collectively within reach of the advanced student and young practitioner, the medical school of London, great as it undoubtedly is, will never take that pre-eminent position which it is entitled to assume amongst the schools of Europe both by the acknowledged ability of its teachers or the immensity of its clinical opportunities. The system that at present exists in London is so well known as scarcely to require description. It is as follows:—The student "enters" to one particular hospital and continues a pupil of it till he has passed his examinations. He is limited to the practice of that hospital and to the clinical instruction of the medical staff connected with it. The fees that he has paid for these privileges are considerable, and he is shut out from attendance on the practice or the clinique of any other hospital unless he chooses to "enter" it and to pay another fee for clinical instruction. This, I need scarcely say, is very rarely if ever done. He continues through life, as a rule, attached to his own hospital, with the traditions of which he is imbued and with the practice of which alone he is acquainted. The choice of the hospital preferred by the pupil is usually determined by convenience of locality, or by some personal acquaintance with a member of the staff or some former student, rather than by any special regard to the merits of the particular hospital as a place of instruction, of which probably neither he nor his friends are competent judges. The evils arising from this condition of things are not felt in the earlier part of the student's career, but they become manifest later on. The five years' curriculum now required by the licensing corporations may be carried on anywhere, at any medical school in London or the provinces. Any medical school that is recognised by the Royal Colleges may be taken to be fairly equipped, and its teaching fully sufficient for carrying the pupil through his education up to a good minimum pass examination, such as that of the Conjoint Board or the M.B. of most British universities.

My remarks therefore do not apply to the pupil who is preparing for his examinations, but to the student in the subsequent and more important part of this career when qualifying for the M.D. degree or seeking to perfect his knowledge. Indeed, I consider it to be very important that the study leading up to the pass examinations should be carried on at one medical school only and under one set of teachers. The same subjects are taught in all the medical schools and cannot vary. But the method of teaching these subjects and the manner in which they are handled vary greatly, and this is true not only with regard to subjects that admit of much difference of opinion, but even of such as ordinary descriptive anatomy, which are little more than a mere collection of facts to be committed to memory. By going from one school to another the pupil would have to change his method, which would result in much confusion and loss of time. That faculty of sustained attention, also so important, but also so difficult of attainment by the young, would be likely to suffer. In any scheme of federation the larger and more important special hospitals—such as those I have already mentioned—should be included. Much valuable information is to be obtained in them in respect to the diagnosis and detail of treatment of the class of cases with which each hospital is specially concerned. Much is to be learnt by the advanced student in the opportunity he would there have of observing and comparing large numbers of cases of allied diseases, and he would be able to do this under the most favourable circumstances, as many of the physicians and surgeons of the special hospitals are skilled and experienced teachers in the general medical schools. The twenty-seven Poor-law infirmaries offer—as has already been said—enormous and varied opportunities for clinical study. But their organisation and admission into any general scheme of medical education would be attended by some difficulties, owing to the nature of their government, and I would defer the consideration of this part of the subject to some other time, contenting myself for the present with merely pointing out the vast amount of clinical material stored up in these 13,285 beds, and in the vast opportunities for the study of mental diseases afforded by the great lunatic asylums in and around the metropolis. The establishment in London of a Teaching University to which the medical schools would be attached as constituent colleges would be a most favourable occasion for the federation (for clinical purpose) of the hospitals connected with those schools, and for the mutual interchange of students during the final two years preceding the examination for the M.D. degree, under certain restrictions to be agreed upon by the colleges and the Council of the University. The scheme that I would venture to suggest for the purpose of hospital clinical federation is briefly as follows: On the admission of a medical school as a constituent college of the new Teaching University it should become a member of the hospital federation. The admission of any given school as a constituent college would be voluntary, but a condition of such admission should be that it become federated, so far as advanced clinical hospital instruction is concerned, with the other constituent medical colleges. The federated hospitals should be open for the purposes of clinical instruction to all those students who intend to present themselves for examination for the M.D. degree of the new university, no student being admissible to such instruction until after having obtained a registrable qualification and only during the final period of two years of study; no student *in statu pupillari* being admissible to any other instruction than that which is given at his own particular hospital. Admission to the clinical instruction of the federated hospitals should be by ticket, to be issued by the university, for which no fee should be paid by London students beyond a small one, say of one guinea, to meet the expense of registration and to ensure the *bona fides* of the applicant. In the case of the provincial students who had not previously entered to the practice of any of the metropolitan hospitals an entrance fee should be paid to the university, the amount and disposal of which may from time to time be determined by the Council; or, by entering directly to the practice of one of the federated hospitals, he would be placed in the same position as a London student. In the case of the special hospitals that have become federated a small fee should be charged, such as is now paid for attendance on post-graduate classes, and as attendance on these hospitals is now recognised by the Royal Colleges as part of their five years' curriculum, no difficulty need be anticipated here. Special arrangements would require to be made with the metropolitan infirmaries and asylums for the admission of a limited number of students to their practice and residence in an official capacity in these institutions, and at the larger federated special hospitals might be held to count for a part at least of the final two years' clinical study. The requirement from the candidates for the M.D. degree of a residence in London and attendance for a period of two years at one or more of the colleges of the new Teaching University of London is in strict conformity with the rule of every other teaching university in Great Britain. The four Scottish universities all require residence as an essential preliminary to admission to examination for their degrees. So likewise do the four teaching universities of England. On what ground, therefore, can this be refused in the Teaching University for London? If the principle of residence be right for Edinburgh and Glasgow, Aberdeen and St. Andrews, for Oxford and Cambridge, Durham and Manchester, how can it be wrong for London? If not necessary for the London student, on what ground can its necessity be urged for those of other universities of a similar scope as that for London? The M.D. degree should not be given before the age of twenty-four, two years subsequently to the time at which the registrable qualification has been obtained. These two years should be devoted to the attainment of proficiency in clinical medicine in the

federated hospitals and to the practical subjects connected with it. Two years so spent would be undoubtedly the most important in the career of the student. When once he has emerged from his pupilage and has obtained his registrable qualification he may disembarrass his mind of a vast amount of detail with which it has been encumbered for the purposes of passing successfully the dreaded ordeal of the various examinations leading up to the attainment of his diploma, and he is then free to devote himself specially to clinical medicine and to such other scientific and practical work for which he may have special aptitude or natural inclination. The whole of the day cannot, and need not, be spent in clinical study and observation. Much time should be given to it, but much may also be reserved for practical study and work in the laboratories of physiology, pathology, bacteriology, hygiene and forensic medicine. These scientific departments of medicine should occupy his attention as well as clinical medicine, for in them should his examination for the M.D. be conducted, and to proficiency in them must he look for success as a scientific practitioner in future life. In the study of such subjects as those which are comprised in what are termed "post-graduate" courses the student will find the most useful and profitable employment during the final two years that should intervene between his ordinary "pass" and his ultimate M.D. examination. He will now have been emancipated from his own particular school—from that school of medicine in which he has received his education up to the period of his pass, and he will naturally seek for instruction in the higher and more scientific branches of his profession wherever the fame of the teachers is highest and the equipment of their laboratories the most complete. Should this be in his own school he will naturally remain there. Should superior attractions and opportunities present themselves elsewhere he will—if wise—not allow himself to be fettered by old ties and traditions, but get the best instruction from the best teachers and in the best equipped laboratories, wherever they are to be found. He will find that every clinical school presents some special distinctive feature or method of its own, differing perhaps widely from that to which he has heretofore been accustomed, but well deserving careful study and comparison. His horizon will be widened. He will learn no longer *jurare in verba magistri*, but to form juster conceptions in science and to take broader views in practice than he possibly could when confined to the narrowing influences of the teaching of one set of men and the traditions of one hospital only, and he will be led to form a clear and considerate judgment on men whose opinions, though differing from those of his own teachers, he may yet find not to be entirely erroneous or undeserving of consideration.

THE THIRD REPORT OF THE LORDS' COMMITTEE UPON METROPOLITAN HOSPITALS.

THE third and final report issued by the Lords' Committee upon Metropolitan Hospitals has now been made public and contains, in addition to a summary of the evidence submitted, the conclusions at which the Committee have arrived. These conclusions are conveniently distributed under a series of headings, and, although too voluminous for quotation unabridged, may be conveniently summarised as follows:—

ENDOWED HOSPITALS.

In the case of the three endowed hospitals, the Committee are of opinion that the system of administration does not on some points compare favourably with that which exists at the other general hospitals. It throws too much power and responsibility into the hands of one individual, the treasurer; though at St. Thomas's Hospital a larger share in the administration is assigned to committees than at the other two. The Committee would suggest that in all these endowed hospitals the government should be carried on by a system of weekly boards and subcommittees.

REMAINING GENERAL HOSPITALS AND SCHOOLS.

Their systems of management greatly resemble one another, and the evidence shows that they are generally well administered. The Committee note the enormous amount of work done by unpaid boards of managers and the care exercised, so far as the Committee are able to judge, in the appointment of their medical as well as other officers. The Committee desire to refer to the personal nursing dispute appearing in the evidence of the London Hospital. The authors of these charges were for some time nurses and probationers in this hospital, some of whom did not remain during the whole period of training, and of whom two at least stated grievances of their own which were not confirmed by the evidence; and the late chaplain, who for some time before the termination of his connexion in that capacity with the hospital, had differences with the Committee both in these matters and also in regard to the performance of his own duties. The charges are on the whole, in the opinion of the Committee, not substantiated by the evidence. The evidence in regard to the injury to the health of the "sisters" appears inconclusive. The Committee consider that the difficulties would have been avoided had the Governing Board in charge of the hospital at that time not allowed their authority to fall into the hands of salaried officers. In justice, however, to the London Hospital, the Committee wish to add that it is an admirable hospital, doing work in a part of London where it confers inestimable benefits upon a very large and very poor population. They therefore think it is deserving of the greatest measure of charitable support. The Committee recognise that it is advisable, under present circumstances, to maintain the individuality of these general hospitals, and they consider that the generous rivalry thus promoted tends to medical and administrative efficiency. The Committee suggest that the fact of not holding the diplomas of the Royal College of Physicians and Royal College of Surgeons of London should not exclude practitioners who have graduated elsewhere from becoming members of the staffs of the general hospitals in London.

CONVALESCENT HOMES.

The Committee remark that the accommodation for convalescents in connexion with the large hospitals is insufficient, only two or three having convalescent homes attached to them; and that this want is met by the authorities of the hospitals subscribing, through the Samaritan Fund, to convalescent homes Owing to the scarcity of accommodation the patients, although not thoroughly cured, are discharged if well enough to leave the hospital. In some cases these patients find their way to the Poor-law infirmaries, in other cases patients suffering from medical complaints have to be kept for long periods in a hospital, although they would recover more rapidly at a convalescent home in the country. Moreover, these patients have to be provided for in the hospital, to the exclusion of those who would be admitted were beds vacant. The Committee avail themselves of this opportunity to direct attention to this need, in the hope that more extensive convalescent accommodation may be provided by philanthropic effort.

OUT-PATIENTS AND DISPENSARIES.

It is considered by the Committee that by the abolition of the out-patient departments medical education would be seriously interfered with, and, further, that on the whole it must be left to the authorities of the hospitals themselves to arrange the organisation of the out-patient department with the view of rapidly attending to the requirements of the public and of insuring as far as they can that the charities shall not be abused. The Committee are of opinion that the charities are not abused to any serious or appreciable extent, nor do they think that it was by any means proved that patients are carelessly treated, or treated by students instead of thoroughly qualified medical practitioners. On reviewing the evidence as to the different systems pursued by the different great general hospitals the Committee think that, on the whole, the system of limiting the number of out-patients per diem is the most convenient. The Committee consider that inquiries should be made wherever experienced officials think there is cause for suspicion, and that the patient should establish a *prima-facie* case for charitable relief. Medical practitioners and the medical officers of free and other dispensaries should be encouraged as much as possible to take advantage of out-patient departments as centres for consultative purposes, and, from the evidence of many hospital witnesses and others, this is already done to a certain extent. In the case of dispensaries and practitioners the patient might be left in the hands of his medical adviser and not necessarily taken into the hospital.

DISTRIBUTION OF HOSPITALS.

It was suggested that certain hospitals might be removed from places where they are not so much required to localities where the accommodation is deficient. The Committee cannot regard this suggestion as practical, but they would strongly advise that more hospital accommodation should be provided south of the Thames, and were it possible to find the site, and were philanthropic endeavours to be made for further accommodation for the sick in London, a large general hospital, say in the densely populated district of Camberwell, would no doubt be of extreme value.

EDUCATION.

The Committee observe that a very useful field for medical instruction is at present closed to students—namely, the Poor-law infirmaries. It was the opinion of nearly every witness that these infirmaries could be usefully opened for clinical instruction. In this the Committee heartily concur. In addition to the large field for instruction which would thus be opened, they agree with the opinions expressed that the presence of students is to the practitioners stimulating, by reason of the observation and criticism which are brought to bear on diagnosis and treatment; and the evidence they have received shows that where a system of clinical classes of students is carried out under proper regulations the patients have no objection to students at their bedsides.

SPECIAL HOSPITALS.

Hospitals for certain diseases of patients—for example, for children—do not appear to the Committee to be open to the criticisms made on special hospitals Lock hospitals form a separate subject for consideration. The Committee think that the nature of the disease and the character of the patients make it desirable that they should be treated in separate buildings, or, at all events, in separate wards from other patients. The Committee have had their attention particularly directed to the fact that patients in these hospitals are in the habit of quitting the hospital in a diseased state on such occasions as the Derby week, fairs &c., for the purpose of pursuing their avocation. The Committee recommend that provisions analogous to those which prevent a patient leaving a hospital when suffering under infectious diseases should be extended to certain venereal diseases. The Committee consider that the charge of abuse is substantiated in regard to some small special hospitals. This class of small special hospitals to which the Committee refer, of which examples appear in the evidence, the Committee do not consider of any real benefit either to the sick or to science They appear to be carried on sometimes in incommodious buildings or under insanitary conditions, and the Committee would deprecate the multiplication of such institutions.

In this connexion the Committee devote a paragraph to the Royal Hospital for Incurables at Putney, in which they recommend the introduction of reforms, including the appointment of a resident medical officer with general control in the absence of the committee, the appointment of a ladies' committee, the exclusive employment of hospital-trained nurses, the giving out of contracts to open tender, and a great increase of the general supervision by the committee of governors. The giving out of contracts by tender is a practice which they recommend for general adoption.

NURSING.

A certain amount of variety exists as to the hours of employment of nurses in the general hospitals in London. The Committee consider that eight hours' work, exclusive of the time for meals, is, as a rule, as much as should be required from nurses in these hospitals. In constructing future hospitals care should be taken that sufficient accommodation for nurses be provided to allow of the hours of nursing being reduced. They would suggest that every nurse in the large and busy hospitals in London should have at least two days off in the month, and that the period of holiday should not be less than three weeks; that not less than one full hour should be allowed for dinner; and while, on the whole, the food of the nurses appears to be good, yet, from the nature of the occupation of nurses, special care ought to be exercised that as well as being sufficient in quantity and in quality it should be served in an appetising manner. To bring about this end the Committee are strongly of opinion that at the nurses' dinner one of the head officials of the hospital should preside, and that the dinners should be frequently visited by members of the governing body. Nurses in the wards should not have their duties increased by doing menial work, such as scrubbing and cleaning grates and lavatories, or other services of a like nature. For that purpose, as is the case in most hospitals, the class of servant termed "ward-maids," or scrubbers, should be employed. While the Committee recognise that the matron must be greatly responsible for the appointment and dismissal and general conduct of the nurses, they are strongly of opinion that no absolute power ought to be given to any matron, but that the appointments and dismissals should be made by the chief executive authority of the hospital. It is to be observed that many hospitals send out nurses after a certain period of training at sums varying from one guinea to three guineas a week to private patients. That these nurses bring considerable addition to the funds of the hospital there can be no doubt. The Committee consider that this is a good practice, but that, to prevent the wards from being denuded of nurses in order to bring funds to the hospital, a separate staff should be employed for this purpose. They are of opinion that the minimum period after which a nurse can be advertised as thoroughly trained is three years; and, considering the large amount of money these nurses can earn for the hospital, the Committee think that a sliding scale commission on their earnings, mentioned as being in practice at one of the large general hospitals, would be a fair addition to their regular hospital wages. Nursing in the Poor-law infirmaries differs in various institutions. In some a large proportion of nurses are hospital trained; but the Committee regret to find that one-half of the matrons are not regularly trained nurses. The Committee are strongly of opinion that not only all matrons, but that all nurses in a Poor-law infirmary should be trained nurses; the Committee would recommend that no nursing whatever should be done in infirmaries by paupers. The Committee consider that the number of nurses should be increased throughout the infirmaries and that infirmaries should train their own nurses.

PROPOSED CENTRAL BOARD.

This proposal has been already made public, but as it reappears in this report we quote it textually for the sake of giving completeness to our extracts :—

PROPOSED CENTRAL BOARD.

Various proposals for a central board are set out on pages 1 to lili of this report. The Committee do not incline absolutely to any one of these proposals. They are of opinion that, as there is no Government grant, the interference of a Government officer for inspection would be unwise, and they think such interference would tend to check the flow of voluntary contributions and to some extent to interfere with the responsibility of the unpaid boards of managers. The Committee do not think that such a central board should be given any statutory powers as regards the formal licensing of any hospital built or about to be built. They would recommend that the proposed central board should be granted a charter to entitle it to receive endowments, legacies, bequests and contributions for distribution to medical charities and to meet its own necessary expenses. The board might be organised in the following way:—The various hospitals and dispensaries of all kinds should be grouped. The smaller hospitals should be grouped according to the classes of disease which they treat. Each general hospital, with or without a school, might be considered to be equivalent to a group. Each group would send one or more delegates to be members of the central board. The heads of the great medical corporations—e.g., the Royal Colleges of Physicians and Surgeons, the Medical Council and the Society of Apothecaries—might become members of this central board. The free and part-pay dispensaries might send one member and the provident dispensaries also one member. The Hospital Saturday and Sunday Funds might each send one member. A table is attached suggesting details for the formation of such a board. The duties of this board might be of the following nature:—1. It should receive annual reports, statements of accounts and balance-sheets from all hospitals and dispensaries, together with a return of the total number of in-patients, out-patients and casualty patients. 2. It should require that all accounts be audited by competent chartered accountants. 3. It should arrange that all medical charities should be visited and reported on periodically. 4. It should report from time to time, as occasion required, all proposals for new hospitals. 5. It should publish an annual report the principal heads of which might be as follows:—(*a*) A complete statement as to the pecuniary position of each medical charity. (*b*) A statement by a competent authority as to the existing sanitary condition and ventilation of each hospital, and as to arrangements concerted with the Metropolitan Fire Brigade. (*c*) An account of the number of beds in use, the number of beds unoccupied, and the reasons why they are unoccupied. The average daily number of occupied beds, details as to beds for which payment is made, and the number of resident medical staff, resident officers, nurses and servants. (*d*) A statement as to the method according to which each hospital deals with its out-patients and casualty patients, and the number of each. (*e*) Proposals for the removal of hospitals and dispensaries to places where further hospital or dispensary accommodation is required, and the proposals for the establishment of new hospitals, and all other matters of interest relating to the treatment of the sick poor. (*f*) The nursing at hospitals and the proceedings of nursing associations in the metropolis. 6. The proposed board should early turn its attention to the possibility of so organising medical charities as to secure their coöperation with one another and the coöperation of medical charity with general charity.

THE ASSOCIATION OF FELLOWS OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

A MEETING of the Committee of the Association of Fellows of the Royal College of Surgeons of England was held at 36, Grosvenor-street, on Oct. 26th, 1892, Mr. George Pollock, President, in the chair. The meeting had been called to consider what resolutions should be proposed at the annual general meeting of the Fellows and Members on Nov. 3rd. The minutes of the last meeting having been read and confirmed, the hon. secretary reported that "the reply" drawn up at the last meeting had been revised and forwarded to the official of the College concerned therewith. It was agreed that this reply should be entered on the minutes. A letter was read from Mr. W. G. Dickinson, joint secretary of the Members' Association with Mr. Jabez Hogg, inquiring as to the action, if any, which the Association of Fellows intended to take at the general meeting of Fellows and Members on Nov. 3rd, and intimating a desire that the Members' Association should follow the lead of the Fellows' Association instead of taking independent action as heretofore. A long discussion ensued, and it was ultimately agreed to invite the support of the Members' Association to the following resolutions :—

1. "That this meeting of Fellows and Members desires to thank the Council of the College for acceding to their wishes in the matters (1) of separate meetings of Fellows and Members and (2) of the provision of a common room in the College."

2. "That this meeting of Fellows and Members wishes again to impress upon the Council that it is absolutely essential for the welfare of the College that the Fellows and Members should be consulted before any change is made in the constitution and external relations of the College, and before the College is committed to any extraordinary expenditure on buildings or otherwise."

The honorary secretary was directed to forward a copy of these resolutions to the honorary secretary of the Members Association. The meeting then adjourned.

CHOLERA.

CURRENT NOTES, COMMENTS AND CRITICISM.

THE latest official statistics from Hamburg show that the recent epidemic of cholera there had resulted in 17,972 attacks and 7610 deaths. On Monday last it was announced for the first time for ten weeks that there had been no fresh case of cholera or death from that disease on the previous day. It is alleged that some of the cases previously reported had not on bacteriological investigation proved to be true cholera, and the authorities at Hamburg have decided to discontinue the daily publication of cases of choleraic disease in future and limit it to such cases as are certified to be true cholera. The disease prevails to a slight extent in Holland, thirteen deaths from cholera being reported throughout that country last week. From Bruges we learn that a limited but sharp outbreak occurred in the commune of Coolkerke, West Flanders. There are a few fresh and fatal cases at Utrecht, Huissen, Ysselstein, Hendrik and Ambacht. At Budapest the disease continues, though not to any great extent, and a few cases, most of which terminated fatally, occurred at Tat in the county of Gran. The disease seems to have dis-

appeared at Vienna. Indeed, it is said that the cases which have occurred were only cholera nostras. The issue of daily bulletins from Vienna has been suspended, as no cholera now, at any rate, exists in that city. The authorities appear to have wisely made some preparations and arrangements in anticipation of any outbreak, and the Emperor Francis Joseph at the end of last week inspected the chief cholera barracks and expressed his satisfaction with that establishment, speaking at the same time in high terms of the services rendered by the Vienna medical students to that institution. The cholera returns for the month of October show that in Galicia 136 deaths were registered as due to the disease. In Bohemia one death only was recorded. An outbreak has occurred in Servia, and the Bulgarian Government has established a military cordon along the Servo-Bulgarian frontier. Cholera does not appear to be prevalent in any part of Germany, and no bulletin was issued by the Berlin Sanitary Board on the 1st inst. At St. Petersburg the disease had not entirely disappeared, a few cases having occurred towards the end of last month. It is interesting to note that France has been modifying her views regarding a stringent quarantine system and considers that some of the measures imposed by Egypt and other countries are excessive and seriously injurious to the trade of Marseilles, the great French Mediterranean port. We are sincerely glad of this, for it is highly important that in all matters of public and international hygiene we should have the coöperation of a highly cultured, intelligent and scientific people like the French. The matters involved are those of public health and safety, and should be decided entirely on sanitary grounds and on the broad cosmopolitan principle of what is right and best for all, and separated from purely political considerations. No anxiety appears to exist on the Continent as to the epidemic prevalence or extension of cholera during the winter, although it is regarded as quite possible that the disease may not altogether die out. A certain amount of apprehension, however, very naturally exists as to the probable revitalisation and extension of cholera later on next year. Be this as it may, there are certain points and features connected with this epidemic that are both interesting and noteworthy. As regards the results of bacteriological examinations in most of these outbreaks of cholera, the earlier cases—those premonitory, as it were, to the outbreak—were alleged at the time to be only cholera nostras, in which unequivocal specimens of Koch's comma bacilli were either not present or only organisms of a closely allied morphological character were discovered; and towards the end of an outbreak of epidemic cholera, when the number of cases was rapidly tailing off, the same phenomena seem to have been observed. In the Paris epidemic, again, there was a circumscribed epidemic of the disease of apparently little or no infective intensity. It prevailed for a considerable time, showed little tendency—for some time at any rate—to spread, and yet, in point of fatality, was attended with a mortality quite equal to that of epidemic Asiatic cholera. That it was, in fact, true cholera seems undoubted, and is now universally admitted. But the French bacteriologists do not appear to have satisfied themselves that the organisms discovered during the whole course of the epidemic in the dejections of persons suffering from the disease were morphologically identical with those described by Koch after his investigations in Egypt and India; and some authorities in France have gone so far as to declare that the cholera which prevailed in the vicinity of Paris and the Seine had not been recently introduced, but was a product of the revitalised germs left by a previous epidemic which happened years before. It does not yet seem to have been definitely settled when the comma bacilli cease to be discoverable in the dejecta of a cholera patient. We seem now to have reached a stage in connexion with the relation of the comma bacillus to cholera in which it requires to be determined whether there are several comma-shaped organisms of closely allied morphological appearances developed in different diseases characterised by hyper-secretion of the intestine, and what is their relation to one another; and whether the predominant form is in any measure attributable or not to the nature of such secretion. The publication of the observations made by the bacteriologists of different countries where the disease has prevailed is awaited by all who are interested—and who are not?—in the scientific study of this disease.

As regards the port of London, we notice that on the 1st inst. the ship *Ossian* from Odessa was detained at Gravesend and disinfected on account of having a case on board with suspicious symptoms of cholera. The patient was removed to the port sanitary hospital for treatment.

Whilst this cholera epidemic in Europe has been occupying our attention, it appears, according to advices from China, that an extensive outbreak of the disease had occurred in that country, notably at Cheng Ten, where the mortality has been something appalling. Up to Sept. 26th the number of deaths is alleged to have reached thirty or forty thousand.

EPSOM COLLEGE.

WE have been asked to publish the following report of the School Committee of the Council of the College. It will be seen that, on the whole, the report is highly satisfactory:

The school committee have been carefully considering an exhaustive report from members of the school and finance committees, on the dietary supplied to the masters, pupils and servants of the College. A visit was recently paid without any notice being given to the College officials. The bread and butter are excellent. Good oatmeal porridge is supplied to the boys on alternate mornings. The tea is an excellent article supplied by a first-class London house. It is weighed—as is also the white sugar—and the milk measured when the tea is prepared for breakfast and tea. Unsweetened tea is supplied for those who prefer it. The diet table for fourteen consecutive days has been laid before us. The variety of the meat, and its mode of preparation, is satisfactory. The variety of vegetables is good, and the puddings daily supplied meet with our entire approval. The meat is boiled or roast, of first-class quality, and stews or curries are given so that boys may have a choice of dishes not less than twice a week. The vegetables are good and well cooked, and comprise potatoes, cabbage, turnip-tops (carrots, turnips and onions in the stews), lettuces and beetroot. The puddings are given daily, and comprise raisin puddings, current dumplings, bread-and-butter puddings, rice pudding with jam, and suet pudding with treacle or jam. Rhubarb is given in season, and cooked fruit as the markets permit. All these are carefully prepared and the masters partake of them at the same table as the boys at the mid-day meal. The provision of a first-class education with a good, wholesome, well-varied dietary strains the pecuniary resources of the College to the utmost. But the headmaster has advised the committee that a glass of milk in the early morning during the winter months would be of service. Your committee therefore recommend that half a pint of milk be supplied to each boy before he begins work. It is computed that this will cost about £30 per annum. In considering the question of supper no change for the present will be made. Beer has always been provided. It is good and wholesome. Luxuries we do not profess to give. The fees paid do not admit of it; and it is more than doubtful whether they are not harmful to growing lads. Delicate boys who need extra diet must pay for it, as in other schools. That the administration of the school in the past has been successful is proved—first, by the low rate of sickness, except when epidemic disease has been imported; secondly, by the reports of the examiners of the form work and by the successes of the boys who (going straight from the College) win distinctions at the universities, the hospitals and elsewhere, and enter the public services. This shows that the nerve forces of the boys are well nourished; and, lastly, but by no means least, the successes of the boys in the playing fields show beyond power of contradiction that their muscles are well nourished and well developed.

The authorities of the College are at all times willing to listen to any suggestions for the benefit of the pupils. It is hoped that parents will more frequently come and see how their sons are cared for. If this is impossible, written and signed communications will receive courteous attention in the future, as has always been the case in the past.

J. FAYRER, Chairman.

Public Health and Poor Law.

LOCAL GOVERNMENT DEPARTMENT.

REPORTS OF MEDICAL OFFICERS OF HEALTH.

Derby Urban District.—According to the census returns the Derby death-rates had to be considerably amended, but that for 1891 was not high—namely, 18·9 per 1000—compared with similar boroughs. The zymotic rate, which was 1·3 per 1000, was distinctly below the decennial average. Scarlet fever attacked 318 persons during the year, of whom 62 per cent. were removed to hospital. Derby having a new modern and attractive institution; and Mr. W. Iliffe speaks in high terms of the value of the building as a preventive against the spread of infection. In all, 398 cases of infectious disease were notified, and it is stated that no attempt at concealment took place, the system of notification having worked well. The infectious hospital was unable to meet all the demands made upon it, such is the result of the provision of a proper establishment. Evidently the erection of another pavilion is called for. Mr. Iliffe also recommends a building for convalescents. This involves a secondary question. If the 2000 cubic feet with

wall space &c. allotted to the beds at present are all occupied by acute cases, the results as regards recovery may turn out to be different from that which has hitherto been the case—a point deserving of consideration. The appendices to the report show that an efficient sanitary administration is efficiently maintained.

Wolverhampton Urban District.—Both measles and scarlet fever have been causes of anxiety in this borough, and a list is given in the annual report of cases where neglect, due to ignorance or intention, was the means of spreading the disease. A new pavilion at the hospital became necessary, and it was accordingly erected; and, as regards scarlet fever, Dr. Malet points out that in a number of instances the infection was apparently carried home by discharged patients, owing to the lack of proper means of bathing &c., before discharge. It is certain that such means can only be adequately provided by a separate building containing bath- and dressing-rooms, for if patients have to dress before discharge in the same building where infection exists it is impossible to say that they are incapable on discharge of conveying infection with them. But, whilst a discharge-room thus becomes necessary, we are convinced, as the result of considerable experience of which we have been made aware, that the essential cause of the apparent communication of scarlet fever by persons discharged as cured from scarlet-fever hospitals lies in the recrudescence of sore-throat in scarlet-fever patients and the absence of warning as to the results which are almost certain to ensue on such recrudescences. Wolverhampton had a death-rate of nearly 23 per 1000 during 1891.

Dumfries County.—Dr. Maxwell Ross, in presenting his first report on the sanitary condition of this county, sets out in considerable detail all those matters relating to topography, meteorology, population, dwelling accommodation, water supplies, streams, means of sewerage, industries &c. which are necessary to a proper apprehension of the conditions which have to be dealt with for public health purposes. The diseases which have prevailed in the constituent areas are discussed under separate headings, as are also the vital statistics. The report is, in short, a valuable work of reference with regard to all the circumstances affecting health, and with regard to mortality and other statistics up to current date, and will serve admirably as the introductory report to a series which we may hope will follow in succeeding years. With one point Dr. Ross deals separately in an appendix—namely, the subject of Hospital Accommodation, and it is quite evident that he attaches much importance to the necessity of providing means of isolation as a necessary supplement to compulsory notification of infectious diseases and as a necessary preliminary to disinfection of premises. He quotes much from the standard report on this subject issued by the English Local Government Board, and he sets out concisely the conditions under which the provision of means of isolation is likely to become a success on the one hand or a failure on the other. Dr. Ross apparently sees no reason for dealing with small-pox on such distinct lines as have appeared necessary to us; indeed he would evidently place his small-pox pavilion on the same site as that devoted to the ordinary infectious fevers. The explanation seems to lie in the fact that he apprehends the occurrence of but little small-pox; it is only thought likely to occur with comparative rarity and in small numbers. What the limit is as regards numbers in which there is danger of aerial diffusion of the infection we do not know; it probably varies much according to those unknown conditions which make one year favourable to the production of an epidemic and another unfavourable to it, that which is sometimes termed the epidemic influence. But until we understand what this involves, undue aggregations of small-pox cases should be avoided in proximity to dwellings or adjacent hospital buildings.

Huddersfield Urban District.—Dr. J. R. Kaye introduces into his annual report a "balloon view" of the borough, which gives an excellent indication of the topographical features of the district. Huddersfield had in 1890 the lowest zymotic rate of the twenty-eight large English towns, but last year it took a position nearly midway down the list; the general death-rate was also by no means low—namely, 22·9 per 1000; measles, influenza and whooping-cough being the chief factors in the increase of mortality. These three diseases are, so far as we can learn, only indirectly, if at all, affected by common insanitary conditions, and under these circumstances this increase is not one to cause anxiety. On the other hand, it must be a matter of gratification that the Birkby Hospital continues to serve such excellent purposes. Thus no less than 325 cases of scarlet fever were under treatment there during the year—namely, some 86 per cent. of the notified attacks. The hospital is in some respects by no means one of the best or most modern, and the result attained speaks well for its administration and for the growing public confidence in it. The influence of schools in spreading infectious diseases is described by Dr. Kaye, who lays down for the purposes of school teachers a few indications of the first symptoms of the diseases most commonly met with amongst scholars, so that they may be easily recognised in their earliest stages. Cellar dwellings seem to need considerable attention in Huddersfield, and the details given concerning them leave no doubt but that a number of them are, for obvious reasons, unfit for human habitation. Cowsheds, milkshops, bakehouses, slaughter-houses, common lodging-houses &c., all come in for comment as the result of the inspections to which they have been subjected. As regards slaughter-houses we should be glad to learn that in this and in all large towns none but public abattoirs were resorted to. But that day has hardly been reached by our sanitary authorities or by our legislators. Dr. Kaye's report, which is prepared not only for the immediate purposes of the current year, but as a permanent record intended to be of value for reference and other purposes, is an excellent type of what such a report should be. We are promised a further report on the survey of each of the districts into which the town is divided. This will carry with it a gradual house-to-house inspection, which must be regarded as one of the most useful of local sanitary measures—the one, in fact, on which intelligent measures of improvement can best be based.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

In thirty-three of the largest English towns 5955 births and 3808 deaths were registered during the week ending Oct. 29th. The annual rate of mortality in these towns, which had been 17·3 and 18·0 per 1000 in the preceding two weeks, further rose to 19·5 last week. In London the rate was 18·5 per 1000, while it averaged 20·2 in the thirty-two provincial towns. The lowest rates in these towns were 12·3 in Croydon, 13·0 in Bolton, 13·3 in Sunderland, and 15·0 in Wolverhampton; the highest rates were 23·9 in Preston, 24·2 in Birkenhead, 25·2 in Hull, and 33·5 in Salford. The 3808 deaths included 406 which were referred to the principal zymotic diseases, against 389 and 387 in the preceding two weeks; of these, 96 resulted from measles, 82 from diphtheria, 78 from scarlet fever, 75 from diarrhœa, 37 from "fever" (principally enteric), 36 from whooping-cough, and 2 from small-pox. No fatal case of any of these diseases was recorded last week in Derby; in the other towns they caused the lowest death-rates in Blackburn, Sunderland, Burnley and Sheffield, and the highest rates in Oldham, Halifax, Brighton, Hull and Salford. The greatest mortality from measles occurred in West Ham, Oldham, Bradford, Hull, Brighton and Salford; from scarlet fever in Salford and Plymouth; from "fever" in Preston; and from diarrhœa in Wolverhampton, Oldham, Bolton, Hull and Gateshead. The mortality from whooping-cough showed no marked excess in any of the large towns. The 82 deaths from diphtheria included 56 in London, 4 in Halifax, and 3 in Birmingham. One fatal case of small-pox was registered in Halifax and one in Bradford, but not one in any other of the thirty-three large towns; 4 cases of this disease were under treatment in the Metropolitan Asylum Hospitals and 2 in the Highgate Small-pox Hospital on Saturday last. The number of scarlet fever patients in the Metropolitan Asylum Hospitals and in the London Fever Hospital at the end of the week was 4012, against 3628, 3797 and 3936 on the preceding three Saturdays; 410 new cases were admitted during the week, against 503 and 484 in the preceding two weeks. The deaths referred to diseases of the respiratory organs in London, which had increased from 114 to 267 in the preceding eight weeks, further rose last week to 296, but were 78 below the corrected average. The causes of 83, or 2·2 per cent., of the deaths in the thirty-three towns were not certified either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in Leicester, Bolton, Preston, Sunderland, and in five other smaller towns; the largest proportions of uncertified deaths were registered in West Ham, Birmingham, Sheffield and Hull.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in the eight Scotch towns, which had been 18·0 and 19·0 per 1000 in the preceding two weeks, further rose to 20·3 during the week ending Oct. 29th, and exceeded by 0·8 per 1000 the mean rate during the same period in the thirty-three large English towns. The rates in the eight Scotch towns ranged from 14·1 in Dundee and 14·5 in Paisley to 22·3 in Greenock and 22·5 in Glasgow. The 564 deaths in these towns included 43 which were referred to measles, 14 to scarlet fever, 12 to diphtheria, 10 to whooping-cough, 9 to diarrhœa, 2 to "fever," and not one to small-pox. In all, 80 deaths resulted from these principal zymotic diseases, against 75 and 87 in the preceding two weeks. These 80 deaths were equal to an annual rate of 3·2 per 1000, which exceeded by 1·2 the mean rate last week from the same diseases in the thirty-three large English towns. The fatal cases of measles, which had increased from 12 to 39 in the preceding five weeks, further rose to 43 last week, of which 20 occurred in Edinburgh, 12 in Aberdeen, 6 in Glasgow and 5 in Leith. The deaths referred to scarlet fever, which had been 16 and 15 in the preceding two weeks, further declined to 14 last week, and included 10 in Glasgow and 3 in Edinburgh. The fatal cases of diphtheria, which had been 2 and 5 in the previous two weeks, further rose to 12 last week, of which 6 occurred in Glasgow and 4 in Edinburgh. The 10 deaths from whooping-cough corresponded with the number in the preceding week and included 7 in Glasgow. The 2 fatal cases of "fever" were fewer than those recorded in any recent week, and the deaths from diarrhœa also showed a decline. The deaths referred to diseases of the respiratory organs in these towns, which had been 82 and 97 in the preceding two weeks, further rose to 138 last week, but were 20 below the number in the corresponding week of last year. The causes of 55, or nearly 10 per cent., of the deaths in the eight towns last week were not certified.

HEALTH OF DUBLIN.

The death-rate in Dublin, which had been 20·7 and 19·4 per 1000 in the preceding two weeks, rose again to 25·8 during the week ending Oct. 29th. During the first four weeks of the current quarter the death-rate in the city averaged 21·5 per 1000, against 17·4 in London and 20·6 in Edinburgh. The 173 deaths in Dublin during the week under notice showed an increase of 43 upon the number in the preceding week, and included 6 which were referred to different forms of "fever," one to whooping-cough, one to diarrhœa, and not one either to small-pox, measles, scarlet fever or diphtheria. In all, 8 deaths resulted from these principal zymotic diseases, equal to an annual rate of 1·2 per 1000, the zymotic death-rate during the same period being 2·0 in London and 6·3 in Edinburgh. The fatal cases of "fever," which had been 4 and 2 in the preceding two weeks, rose to 6 last week, a higher number than has been recorded in any week since April last. The 173 deaths registered in Dublin last week included 28 of infants under one year of age and 39 of persons aged upwards of sixty years; the deaths of infants showed a further decline from those recorded in recent weeks, while those of elderly persons showed a further increase. Four inquest cases and 3 deaths from violence were registered; and 54, or nearly one-third, of the deaths occurred in public institutions. The causes of 13, or nearly 8 per cent., of the deaths in the city last week were not certified.

THE SERVICES.

MOVEMENTS OF MEDICAL STAFF.

HON. BRIGADE-SURGEON QUINLAN (retired pay) has been appointed to the Medical Charge at Galway. Surgeon-Major MacNeece and Surgeon-Captains Lendrum and Leishman have obtained leave on medical certificate from Bengal. Surgeon-Lieutenant-Colonel Quill has obtained sick leave from Bombay. Surgeon-Captain Moir has been transferred to Chatham for duty. Surgeon-Captain Shine has been transferred to Castlebar and Surgeon-Lieutenants Chambers and Lewis from Dover to Shornecliffe. Surgeon-Lieutenant Smythe has joined at Pirbright for duty with the Guards. Surgeon-Lieutenant Anderson has rejoined at Portsmouth.

ARMY MEDICAL STAFF.

Brigade-Surgeon-Lieutenant-Colonel George Wm. McNalty, M.D., F.R.C.S.I., has been placed on retired pay.

INDIAN MEDICAL SERVICE.

The officers of the Medical Staff completing their tour of foreign service during the trooping season have sailed in the following troopships from Bombay:—*Crocodile:* Surgeon-Major W. L. Lane, Madras; Surgeon-Captain S. W. Hayman, Bombay; Surgeon-Captain M. L. Hearn, Madras.—*Serapis:* Surgeon-Lieutenant-Colonel W. F. Burnett, Bombay; Surgeon-Captain H. Carr, Bengal; Surgeon R. J. D. Hall, Bombay. *Euphrates:* Brigade-Surgeon-Lieutenant-Colonel G. J. Evatt, Bengal; Surgeon-Captain G. Cree, Bengal; Surgeon-Captain W. R. Crooke, Bengal.—Surgeon-Captain J. Crimmin, V.C., I.M.S., Civil Surgeon, Shikarpore, arrived at Bombay per s.s. *Malwa* on the 8th inst. Surgeon-Captain W. H. Bean, on arrival from England, will do duty in the Madras District, as will Surgeon-Lieutenant P. C. Gabbett; and Surgeon-Lieutenant J. L. Macrae, on arrival from England, will do duty in the Secunderabad District. Surgeon-Captain J. C. Addison, Medical Staff, on arrival from England, has been posted to Mhow District for general duty. Captain A. E. R. Tucker, 1st Battalion Cheshire Regiment, has been detailed for duty at the Regimental Depôt in relief of Captain E. J. Lamb, who will complete his tour of such duty on March 1st, 1893. The following appointments have been made:—1st Bengal Cavalry: Surgeon-Captain G. T. Mould from the officiating to the Medical Charge of the regiment, with effect from August 4th, 1892. 20th Bengal Infantry: Surgeon-Major W. E. Griffiths from the medical charge of the 17th Bengal Cavalry, to the Medical Charge of the regiment. The above transfer is made solely in the interests of the public service. The appointment of Surgeon-Major W. E. Griffiths to the Medical Charge of the 19th Bengal Infantry has been cancelled. Brigade-Surgeon-Lieutenant-Colonel W. Grey and Surgeon-Captain S. T. Avetom, Indian Medical Service, have been permitted by Her Majesty's Secretary of State for India to return to duty. Surgeon-Captain T. D. C. Barry, F.R.S.E., F.C.S., F.I.C., Chemical Analyst to the Government, proceeded on special leave to Europe on the 6th ult. The services of Surgeon-Captain C. M. Moore, Indian Medical Service, are placed at the disposal of the Government of India in the Foreign Department. The temporary rank of Surgeon-Colonel has been conferred on Brigade-Surgeon-Lieutenant-Colonel S. B. Hunt, while officiating as Principal Medical Officer of the district in the Madras Command. Mr. Frank Bradley, Civil Surgeon, Lashio, has passed the Higher Standard Examination in Burmese, and is the first medical officer in the Burma Service to attain this literary linguistic distinction.

NAVAL MEDICAL SERVICE.

Surgeon William Hayes has been placed on the Retired List.

VOLUNTEER CORPS.

Rifle: 3rd Volunteer Battalion, the East Surrey Regiment: Surgeon-Captain J. E. Lane, M.D., has resigned his commission.

RECOGNITION OF MERIT.

Lieutenant Geo. F. McMunn, R.A., the son of the principal medical officer of the Chelsea Royal Hospital, Dr. J. Alexander McMunn, has been appointed a Companion of the Distinguished Service Order in recognition of his services in connexion with the recent operations in the defence of Sadon.

THE ISAZAI FIELD FORCE.

We recently called attention to the announcement that no field hospitals had been provided for this force on taking the field, but were in doubt as to the accuracy of the report, for it did not appear clear how the sick and wounded soldiers were to be treated without hospitals of some kind. We find from our contemporary, the *Indian Medical Gazette*, however, that, as a matter of fact, no field hospitals were provided for the force. Corps were supplied with full marching scale of establishment, ambulance transport, and camp equipment. As it happened, Sir William Lockhart's force advanced and captured an unoccupied post, and the force promptly returned to their quarters. Had the circumstances been different, and had the force been detained in the hills and actually engaged in any warfare, we confess that we do not understand how the sick and wounded would have been adequately accommodated and provided for.

A correspondent, writing from Camp Palosi to one of the Allahabad papers on Oct. 7th, regarding the occupation of Baio, while highly praising the work done by Surgeon-Colonel Harvey and the medical officers of the expedition, alludes to the insufficient number of medical officers provided for the work and to the late arrival of stores of various kinds, which he attributes to the economical desires of the authorities. He mentions the fact of an outbreak of cholera—

fortunately of a comparatively mild kind—having occurred (forty cases and fifteen deaths), and alludes to the difficulties that must have arisen had a big action taken place at Baio.

THE NEW RIFLE AND MEDICAL SERVICE REQUIREMENTS.

In the last number of the *Journal of the United Service Institution of India* Captain Cox discusses the subject of the probable changes that will be brought about in warfare by the introduction of the new magazine rifle. The main points in the superiority of the new weapon introduced into the British army are increased range, greater flatness of trajectory, increased penetration and greater rapidity of fire with an absence of recoil. The tactical effects that will follow the introduction of the new rifle do not concern us. The nature of the wounds and the number of the wounded are, however, matters of interest to the medical services. Captain Cox arrives at conclusions in these respects which do not materially differ from those of other authorities and writers on the subject—viz., that the number of casualties from comparatively slight wounds will be largely increased, calling for additional field hospitals and bearer columns to succour and provide for the increased number of wounded, and this will tend to diminish the mobility of an army. It is argued that, as far as field armies are concerned, wars will be decided more rapidly in future. The armies of all nations are supplied more or less with new arms of precision of some kind. As regards the French in Dahomey, we are still without any precise official details of their experience with the Lebel rifle.

THE LATE CYCLONE IN MAURITIUS.

We are glad to notice that the medical service is included in the general order published by the officer commanding the troops in the Mauritius notifying his Royal Highness the Commander-in-Chief's very great satisfaction at the admirable conduct of the force and the important services rendered by the garrison of Port Louis on the occasion of the late cyclone. It appears that a despatch from the Acting Governor of Mauritius to the Secretary of State for the Colonies had called attention to the subject. Among the names of many officers, non-commissioned officers and men who are honourably mentioned, those of the following medical officers occur: Brigade-Surgeon-Lieutenant-Colonel Maunsell, Surgeon-Captain McCulloch and Surgeon-Captain Luther, Medical Staff.

CHOLERA MORTALITY IN INDIA.

Our contemporary the *Indian Medical Record* for October last, quoting from a cholera table, shows a terrible record of deaths from that disease. In fourteen years, from 1877 to 1890, it declares that 1,000,826 persons have died in Bengal from cholera alone.

THE MILITARY FORCES OF EUROPE.

So large are the forces existing at present that Europe may well be styled an armed camp; but taking the figures recently published by the *Cologne Gazette* these forces will become enormous in the near future and altogether disproportionate to any medical service that can be organised, even if we make every allowance for very large additions from the volunteer services and civil medical element of the different nations concerned. According to the extended conscription at present in force the army in France on a peace footing numbers 519,000 men, and she will have in twenty-five years 4,053,000 trained men; in Russia the peace establishment, excluding the army in Asia, is 887,000, and in twenty-three years her army will be approaching 5,000,000. Germany now proposes to recruit for a two years' service and absorb every really able-bodied man, and in that way to raise her army in peace to 492,000 men, exclusive of officers, and it is estimated that she will have at her disposal between 4,000,000 and 5,000,000 of drilled men in twenty-five years' time. It is perfectly clear that only portions of such enormous forces can take the field at a time, for it would be impossible to feed them, to say nothing of providing them with the necessary medical and surgical aid. It can presumably only be intended to put a certain number of army corps in the field and follow them up by others during a campaign. It is a ghastly outlook at present, but twenty-five years is a long time, and the system under which these colossal armies are possible may have altogether broken up in the interval.

REGIMENTAL INSTITUTIONS.

Lord Roberts has been instrumental in starting in India a system of regimental institutions, after the nature of a club, for the use of the soldiers of corps serving in that country, which, according to a correspondent in the *Army and Navy Gazette*, are said to work well in increasing the comfort and well-being of soldiers and in developing habits of sobriety and good order amongst them. The old system of dingy and uncomfortable barrack canteens is stated to be very inferior to that of the newer regimental institutions. Marked and progressive improvements have taken place of late years in all that concerns the social and sanitary conditions of the soldier in India.

Correspondence.

"Audi alteram partem."

"ANNUAL GENERAL MEETING OF FELLOWS AND MEMBERS AT THE ROYAL COLLEGE OF SURGEONS OF ENGLAND."

To the Editors of THE LANCET.

SIRS,—In your annotation of Oct. 29th, under the above heading, you "strongly urge all Fellows and Members who have the good government of the College at heart to attend the meeting on the 3rd and support the resolutions which will then be submitted." It seems to me that not a few Fellows and Members who have the good government of the College at heart will absent themselves from the meeting on the 3rd for the following reasons: 1. Their presence at their own College can at present only carry with it the value of protest; this protestation has already been frequently expressed. 2. Their views on just reform can be promoted, for the time being, with great force and cogency, outside the College; and the drafting of suitable men into the Council in July has far more real significance than a full attendance at the annual meeting in November. 3. The calling together of Fellows and Members indiscriminately—men engaged in an arduous profession—to listen to, maybe to speak on, a bald annual report, yet utterly and absolutely unable to amend or alter it in any respect, is an insult to the Members and a greater stultification of the Fellows.

When, in due course of time, the Members of the College are fairly recognised and Fellows have an authoritative vote on the proceedings of Council, then will be the opportunity for both Fellows and Members to re-enter and prove that criticism need not imply a lack of goodwill nor independence of thought disloyalty to their College.

I am, Sirs, yours faithfully,

Welbeck-street, W., Oct. 31st, 1892. RICHARD DAVY.

PAYMENT TO MEDICAL OFFICERS OF WORKHOUSES.

To the Editors of THE LANCET.

SIRS,—I have just received intimation from the London County Council that they are prepared in future to sanction the payment of medical officers of workhouse infirmaries for giving evidence at the coroners' court and for making post-mortem examinations. This decision has been arrived at upon the opinion of Mr. Poland, Q.C., who has recently been consulted on the matter. It does not necessarily follow that other county councils will take the same view as that which is now adopted by the London County Council, as coroners generally have been guided hitherto by the case of Don Bavaud *v.* Morrison, which was heard before his honour Judge Lushington at the Croydon County Court in 1885, and decided adversely to the interests of infirmary medical officers. It is to be hoped that Mr. Poland's opinion will, however, guide coroners and county councils generally, so that they may come to the same decision as that arrived at by the London County Council. A full copy of Mr. Poland's opinion could doubtless be obtained if required on application to the chief officer, Public Control Department, 21, Whitehall-place, S.W.

I am, Sirs, yours truly,

G. DANFORD THOMAS,
St. Mary's-terrace, W., Nov. 1st, 1892. Coroner for London.

"EXPERIMENTS ON ANIMALS."

To the Editors of THE LANCET.

SIRS,—Dr. Clarke, in his letter upon the above subject, agrees with Dr. Tyson in his appeal for facts in support of vivisection. I shall be glad if you will allow me a short space in your columns to mention some facts connected with operations performed on the stomach and intestines which may, I think, go far towards convincing the sceptical of the utility of experiments on animals in this department of surgery. In the year 1889 I conducted my first series of experiments based upon those described by Professor Senn. I again in 1891 carried out a second series. Details of these experiments have been described in the medical journals and at the medical societies, and the subject is fully treated in my work entitled "Surgical Diseases of the Stomach and Intestines." Until the year 1890 there had not been one successful case of pylorectomy for carcinoma reported in this country. The details of five cases had been published, all of which had been unsuccessful, the patients dying within eighteen hours of the operation. In 1890 Mr. Rawden reported a case of pylorectomy in which he had united the divided ends of the stomach and duodenum by means of decalcified bone-plate. This patient made a good recovery and returned to his work. In July, 1891, I performed the combined operation of pylorectomy and gastro-enterostomy on a woman for carcinoma of the pylorus. This patient is alive and well fifteen months after the operation. She has gained 56 lb. in weight and follows her usual employment. I can only find two recorded cases of gastro-enterostomy reported before the year 1890—one of these recovered and one died eleven days after the operation from exhaustion due to incessant vomiting. Since the publication of the results obtained by experiments on animals gastro-enterostomy has been performed a considerable number of times. I have before me the results of twenty-four cases, of which seventeen made good recoveries. Some of these patients have been operated upon for over two years and are still alive and able to enjoy life. Besides these, a large number of cases of intestinal anastomoses have been performed successfully for the cure of fæcal fistula, gangrene of the intestine due to constriction of the gut in strangulated hernia &c. I venture to assert that these good effects were the direct result of experiments performed on animals, a success which would not have been obtained if the operations and experiments had not been carried out. In other departments in surgery equally great advances have been made by experimental research; but of these I will leave others to speak. I am, Sirs, yours faithfully,

FRED. BOWREMAN JESSETT.

Buckingham Palace Mansions, S.W., Oct. 30th, 1892.

To the Editors of THE LANCET.

SIRS,—The letter of Dr. W. F. Clarke in your last issue indicates the true source of much of the bitterness of the anti-vivisection controversy. The opponents of the practice of vivisection, as Dr. Clarke points out, are not met fairly. While its defenders declare that everything is done under anæsthetics—that if the animals feel any pain it is no worse than the prick of a needle; that every important discovery in medicine, surgery and pharmacology has been made in consequence of it; that its opponents are mere sentimentalists; and so forth—your dispassionate readers, like Dr. Clarke, cannot be surprised that we devote our whole energies to protest against such want of candour on the part of men who cannot use such arguments without some sense of degradation. Hermann of Zurich and Dr. Charles Richet own honestly that they work for science and science only, without bothering their heads about the progress of the healing art or the good of humanity. If English scientists would get rid of this cant some of those who now fight because of their English love of fair play would be able to acknowledge that the defenders of experiments on animals had the courage of their convictions and were not sailing under false colours. While we are treated as a pack of "shrieking sentimentalists" and mere lap-dog philanthropists we feel that we do not receive the justice our cause demands. Meet us fairly and it will be found that we are not quite the sort of people we are supposed to be by some of our opponents.

I am, Sirs, yours truly,

EDWARD BERDOE, L.R.C.P. Edin., M.R.C.S.

Victoria-park, N.E., Oct. 29th, 1892.

HYPNOTISM DURING AN OPHTHALMIC EXAMINATION.

To the Editors of THE LANCET.

SIRS,—I shall be glad if you can find space to publish the following brief notes of a very remarkable case which has recently come under my notice, in which hypnotism was induced during an ophthalmic examination. I have searched all the literature which is at my command and can find no record of any similar occurrence, and shall be glad to learn from any of your readers if any similar cases have been recorded. A woman, aged thirty-six, was admitted on Oct. 22nd into the Northumberland, Durham and Newcastle Infirmary for Diseases of the Eye, under my care, suffering from optic atrophy. She is a very broken-down-looking woman, and, without giving her symptoms in unnecessary detail, I may say that I came to the conclusion that she was in an early stage of general paralysis. Her memory is defective. She does not speak well, clips words, and sometimes misuses them, and probably has some delusions. Her pupils are widely dilated, do not react to light, and in certain directions there is nystagmus. She has occasional bad headaches and her patellar reflexes are much exaggerated. Both discs are very white, and it is doubtful if she can see light. The day after she was admitted she was taken into the dark room for ophthalmoscopic examination. Whilst examining her I observed to the lady superintendent who was present that the patient seemed drowsy, and it occurred to me that she was becoming hypnotised. I left off the examination and making a few passes over her face with my hands I soon found she had passed into a condition of deep sleep. Continuing to make passes with one hand, with the other I raised her left arm at right angles to her body, and subsequently the left. They both remained rigidly in the same posture as that in which they were placed. It was now noticed that both eyes were not equally closed and that there was an evident ptosis in the left eye and partial paralysis of the left side of the face, the mouth being drawn to the right. I now shook the patient and called her loudly, when she gave a deep sigh and woke up. The ptosis and facial paralysis remained marked for a few moments and then disappeared, or at all events became so slight that I should never have noticed it had I not known it existed in a latent form. On asking the patient when she awoke what she had been doing she said that she had had a pleasant sleep and that a headache she had previously disappeared during the time. I suppose this patient, probably owing to cerebral disease, is specially susceptible to hypnotic influences, for I have found that I can always reproduce the same phenomena at pleasure, and have done so before several medical men; but the most interesting feature in the case is that during the hypnotic state certain symptoms should develop which are unnoticeable under ordinary circumstances. The hypnosis here, so to speak, enables the nervous system to cast in advance a shadow of symptoms which the real disease will almost certainly develop at a later period.

I hope some of your readers who are conversant with hypnotic phenomena will say if the same phenomena have been observed in other cases—that is, if patients have exhibited whilst in this condition symptoms of nervous or other derangements which have subsequently become realities, because if this is so hypnosis may occasionally become a valuable adjunct in diagnosis and prognosis. I may say this woman is quite uneducated—I should think has at all times had an intellectual development below the average, and has never heard of mesmerism or any of its methods. She thinks nothing of the phenomena, but tells the other patients that the doctor can put her to sleep.—I am, Sirs, yours faithfully,

C. S. JEAFFRESON, M.D. St. And., F.R.C.S. Edin.

Newcastle-on-Tyne, Oct. 30th, 1892.

"ACUTE INFECTIOUS EPIPHYSITIS."

To the Editors of THE LANCET.

SIRS,—In the annotation on Drs. W. M. Coplin and D. Bevan's paper on the above subject in the *Philadelphia Medical News* of Aug. 13th you mention certain conclusions at which they have arrived and certain opinions with which they are in accord. Permit me to mention that in my paper in the Guy's Hospital Reports, 1890, on this disease I drew the following conclusions:—1. The disease is due to the irritation and suppuration occasioned by the entrance and

development of the staphylococcus pyogenes aureus, and that it is a specific disease and not merely traumatic periostitis which gives rise to death of the shaft. 2. The earliest symptoms appear in the juxta-epiphysial regions and spread thence inwards to the medulla and outwards to the periosteum, assisted by the continuity of the latter with the epiphysial cartilage. To prove this point I made a series of experiments on young rabbits, and in the article in question full details are given. 3. In cases of total death of the diaphysis the destructive process is most marked at the extremities, the bone here being found eroded and gangrenous; and further that there is such a loss that the dead shaft no longer fits accurately into the epiphysial and periosteal cap. You also remark that amputation seems to be the only treatment. With this I cannot agree, as the conclusion I came to was that operators must not merely be content with incising the periosteum and letting out the pus, but should attack the disease immediately at its root by tunnelling the juxta-epiphysial junction in addition, and so allow a sufficient exit for the products of the inflamed medulla.—I am, Sirs, yours faithfully,

A. H. TUBBY, M.S. Lond., F.R.C.S. Eng.

Finsbury-circus, E.C., Nov. 1st, 1892.

"ANALYSIS OF 10,000 CASES OF DISEASE AND DISTURBANCE OF THE EYES."

To the Editors of THE LANCET.

SIRS,—The two instructive instances of unsuspected foreign bodies in the eye related by Mr. Brudenell Carter in his most interesting and practical article in THE LANCET of Oct. 29th recall to my mind one which was perilously near bringing me to unmitigated grief. A nervous young man came to consult me about "something in his eye." I examined him carefully but could detect nothing save violent purulent inflammation of the conjunctiva, and I told him so. It transpired that he had already consulted two medical men in London (where he lives) and that they both considered he was suffering from gonorrhœal ophthalmia, a diagnosis in which I was disposed entirely to agree, especially as I found he had still a troublesome gleet. I prescribed a lotion of boric acid and alum—being antiseptic to the backbone—which he seemed to think "dear at the price." My patient was going away, in no very amiable mood, when he turned at the door and said, "I *know* there's something in it!" "Come back, then, and let me have one more look." I seated him again in a good light, and, with the aid of a powerful pair of glasses (alas, presbyopic!), I was fortunate to discover, by the merest chance, a round black point almost hidden by a loose fold of mucous membrane, which had doubtless concealed it during the previous examinations. With a pointed pair of forceps I had no difficulty in extracting a long, round, sharp, black thorn quite half an inch in length and as thick at one end as a silver probe, which had been embedded in the loose tissue at the external angle of the eye and quite clear of the globe. When pressed for an explanation of its presence he told me that some three weeks previously he had scrambled through a hedge and a twig had struck the eye, but did not hurt it. As he left the consulting-room he muttered irefully, "What jolly fools doctors are!" Grateful!—Let me take this opportunity of adding my humble testimony to that of Mr. Brudenell Carter as to the efficacy of solution of nitrate of silver and the inefficacy of soothing antiseptic washes in the treatment of ophthalmia neonatorum. This was, of course, the universally received teaching in my young days, but the rising generation are nothing if not germicidal. Without at all undervaluing antisepsis it sometimes, I confess, occurs to me that the almighty microbe is getting just a trifle too rampant and requires a little judicious "sitting on."

I am, Sirs, yours truly,

CHAS. EGERTON FITZGERALD, M.D. St. And.

Folkestone, Oct. 29th, 1892.

CHLORIDE OF ETHYL: A WARNING.

To the Editors of THE LANCET.

SIRS,—In THE LANCET of this week, under "New Inventions," Dr. Bengué's instrument for the administration of chloride of ethyl is spoken of in connexion with dental as well as other minor surgical operations. I write this note as a warning, as I believe the inhalation of the vapour is not altogether free from danger. Having occasion to scarify a small patch of lupus erythematosus on the nose of a young lady, I thought it a favourable opportunity to try a chloride of ethyl tube. The spot was frozen well enough, but the patient turned pale, slightly livid and stopped breathing, looking very like a person under nitrous oxide gas. As I took away the ethyl at once she recovered in a few seconds, but I should certainly not use it again to any part of the face where it was possible that the vapour could be inhaled. Chloride of methyl applied by means of a tampon is far safer and easier, but care must be taken not to over-freeze the skin or a dermatitis may be set up.

I am, Sirs, yours faithfully,

Harley-street, W., Nov. 1st, 1892. H. RADCLIFFE CROCKER.

"MEDICAL AID ASSOCIATIONS."

To the Editors of THE LANCET.

SIRS,—In the elucidation of this subject a specific instance of the working of one of these institutions is worth more than a great deal of generalisation. Having been medical officer for five years, from its inception, to one of these associations, I am in a position to supply you and your readers with some particulars which may prove interesting. The Walsall Medical Aid Association was formed in 1885, and I was appointed its first surgeon at a salary of £180 a year, to be raised to £200 as soon as it was found to be a success. This was soon demonstrated, and in the course of twelve months or so the promise of a rise in my salary was fulfilled. By 1887 the Association had close on double the number of members it had at the beginning, and I thought I might now seek for a rise in salary. I may explain that, in addition to the fixed salary of £200 per annum, I had a house free, midwifery fees at 10*s.* 6*d.* each, with vaccination and teeth extraction. The midwifery cases did not quite average one a week. I was allowed one shilling a week from the committee, or paid that amount for the heating and lighting of the surgery, waiting- and consulting-rooms, while I had to pay the coal and gas account of the whole establishment—my house and the surgery &c. being in the same building. When, then, the members had increased so much as to be nearly double, I applied (1887) to the committee for a little relief, which would be tantamount to a small rise in salary—viz., for them to take over and pay from their own account and thus relieve me of the coal and gas account of the whole establishment. I was refused and told that they regarded my position as very superior and that I ought to be content. I was then not in a position, by any means, to defy them, so I was forced to work away for over two years more, till 1889, until the members increased to close on 4500, at the original fixed salary of £200, while all this time a handsome balance to the good was seen to be realised. Was I not, under these circumstances, entitled to a rise? What did they want with the surplus; and by whose exertions was it earned? Fancy a surgeon to this association, that began with 1800 members and now had increased to 4500 or thereabout, only having the same salary for attending to the latter number as he had for attending the former! What can this be called but "sweating"? Furthermore, when the dispenser, who was having £60 a year, asked for a rise with an increase in his work he was refused and a junior qualified surgeon obtained in his stead, at a salary of £100 out-door, who, however, only remained a few months, as he could not get an adequate increase to induce him to stay; and when he was first appointed it was said to me that the management expected that now I had assistance in visiting I should be able to save in cab hire what it took to pay the junior surgeon over the former dispenser. What was all this?—only an attempt to "sweat" the surgeons for the benefit of the estate of the association. The annual report of the year I left (1890) shows that for each member the surgeon was paid on an average 10¾*d.*, while each adult paid 3*s.* 6*d.* and each juvenile 2*s.* per annum. A quarter's contribution from each member went to pay the medical attendance, which is the primary object of these institutions, while the remaining three-quarters' contributions went for extraneous business, a large part of which, no doubt, was expected to be profit at the year's end out of the toil and labour and "sweat" of the unfortunate surgeon. Such has been the working of the Walsall Medical Aid Association from July 1st, 1885, until May 1st, 1890, while I was their medical officer. They had several changes after I left—two or three in the course of a

few months. This reduced their surplus funds, it appears, showing how much of the success—I should say 99 per cent. of it—is due to the medical officer, who is made also a profit accumulator for the institution. I presume this is only a type of many other of these combinations.

I am, Sirs, yours faithfully,

D. RIORDAN, M.D.Q.U.I., M.R.C.S.,

Oct. 25th, 1892. First Surgeon to Walsall Association.

To the Editors of THE LANCET

SIRS,—I should like to say a few words in connexion with the above subject and the letters which appeared in your last issue. Your correspondent "Verax," though he appears to write with a strong bias, is certainly right in some of his points, though wrong in others. He is right in what he says of the wretched pay given to their assistants by the majority of medical men. In my opinion it is nothing less than scandalous that a fully qualified man should have to accept and work harder for it than a mechanic, the miserable pittance usually offered, with the risk of being discharged at any moment of caprice, after perhaps years of service and often worse treatment than any domestic. But this will never be remedied until it is made illegal to employ unqualified assistants at all. "General Practitioner" says a qualified man cannot and will not do the drudgery an unqualified man will. He can and will. His argument that a qualified man is not necessary for club patients because the majority have only fancied ailments will not hold water; for though it is weary work sifting the corn from the chaff the real illness is there, and it requires a man well conversant with disease, and often a good one, to recognise it among the mass of trivialities. It is very much the fault of medical practitioners generally that Medical Aid Associations are able to go on; for if they would keep only qualified assistants and pay and treat them well, the associations would find difficulty in securing officers or members. I am now neither an assistant nor do I keep one, nor am I a resident medical officer to an association; but I was an assistant for a short time, and, though I was fortunate in my principal, my experience of the discourtesy of very many men and the poor pay they offered when I was looking for an appointment thoroughly disgusted me with them, and I do not wonder at men preferring to work for an association. "Verax" is, however, wrong in defending the associations, in accepting as patients those who can afford a fair fee. He asks if there is a case on record of one medical man refusing to take a patient from another at a lower fee. Yes, certainly; myself and many of my medical friends do so constantly if the patient can afford what he paid his previous attendant. Many of us, unfortunately, do undersell; but it is an indefensible practice for a regular practitioner—still more so for an association whose sole *raison d'être* is as a charitable institution and not as a financial concern. As such they should be tabooed by the profession. As to the association returning pence to their members, it is very kind of them; but why not have added them to the officer's salary as a bonus? If the associations would confine themselves to those who can but afford the halfpenny or penny a week, I can see no reason against them, but when they accept patients in a better position, then they go out of their sphere and become piratical. Apologising for the length of this letter,

I am, Sirs, yours sincerely,

Oct. 25th, 1892. FAIRPLAY.

To the Editors of THE LANCET.

SIRS,—As medical officer to one of the best conducted medical associations I consider the statements made by "Verax" to be no defence whatever, and in fact quite outside the question. First, as to the position held by the medical officer. He is the *paid servant* of some person or persons not connected in any way with the medical profession. This is a most undignified and indefensible position. Now "Verax" states "the scanty allowance" he receives is more than he could make in private practice. Then, if this is correct, "Verax" is not, on the face of it, entitled to what he now receives or what he received when an assistant; for if he is not competent to maintain a private practice, he is not competent to hold the post of medical officer to one of these associations, for of necessity the work must be far greater than ordinary private practice, and I am in a position to prove it. Then, again, the assistant to a general practitioner is quite different from the position of a medical officer to an association. In the case of the assistant he is under the control and guidance of the principal, and does actually assist a legally qualified surgeon; whereas the medical officer to an association is the actual principal, does the whole of the work, allows a trading company to absorb the profits, and in return receives very little more pay than he would receive as assistant to a surgeon. As to the midwifery fee, that should be an arrangement between principal and assistant, and bears no relation to the question of attending members of an association for a fee of 10*s.* 6*d.* and handing 3*s.* 6*d.* out of this sum to the association for the honour of attending the confinement. Then, again, when an assistant or locum tenens carries on a practice until it is sold it is quite outside the question, and, besides, is only temporary. I do not think any association would be actuated "by the thought that by dismissing a medical officer they would thereby throw him on the tender mercies of his fellows," when I can instance one association that has had thirteen medical officers in three years! It certainly is systematic robbery for an association to purchase property out of money earned by medical and surgical work. With every confidence I appeal to the General Medical Council to consider the interest and welfare not only of the medical profession but also of the public, who in "sweating" medical men will find the iniquitous system rebound on themselves.

I am, Sirs, yours faithfully,

Oct. 22nd, 1892. L.R.C.P.LOND.

AMPUTATION FOR DIABETIC GANGRENE.

To the Editors of THE LANCET.

SIRS,—I have read with much interest the report of Mr. R. J. Godlee's paper on the above subject. In it he points out that the so-called diabetic gangrene is in most cases dependent upon one of two causes—i.e., atheroma of the vessels or peripheral neuritis. Whilst accepting this statement, I would at the same time venture to draw attention to a type of diabetic gangrene in which both these conditions—atheroma and peripheral neuritis—are present. The recognition of this class of case is, I believe, of considerable value, since we have here to deal with two important causative factors. Amputation in such cases would, I apprehend, be attended by much less beneficial results than in those in which the disease was due to one only of the two causes. I have met with this form of gangrene in three patients, all of whom died. The post-mortem examination in two revealed extensive atheroma of the posterior tibial vessels. The posterior tibial nerves were also found to be the seat of well marked neuritis. This lesion was likewise present, although to a lesser extent, in the sciatic nerve in one case. I believe that amputation would only have accelerated death in these patients.

I am, Sirs, yours truly,

T. DAVIES PRYCE,

Oct. 30th, 1892. Hon. Surgeon, Nottingham General Infirmary.

"MR. BRAXTON HICKS ON UNQUALIFIED ASSISTANTS."

To the Editors of THE LANCET.

SIRS,—The remarks on the case of Robert Barnet in THE LANCET of Oct. 29th are not quite consistent with the facts, and you will doubtless in justice permit me to modify your statements. My surgery, a very short distance from my father's residence, is entirely under my supervision, the visiting and prescribing being done by myself—my assistant, who has passed his hospital curriculum and has had many years' experience, being employed in dispensing, attending midwifery and visiting only in my occasional unavoidable absence. In the particular matter in question the assistant responded to an urgent call, and I saw the patient immediately afterwards. It is entirely untrue that brandy was suggested or given by the assistant, but he ascertained that the relatives had previously to his arrival endeavoured to administer the stimulant to the unconscious man.

I am, Sirs, yours truly,

Upper Kennington-lane, S.E., Oct. 31st, 1892. ROBERT GRAHAM.

THE gold medal for the best essay presented at the University of Durham examinations during the year 1891–92 for the M.D. degree has been awarded to Dr. J. F. Johns, of the London Hospital.

LIVERPOOL.

(FROM OUR OWN CORRESPONDENT.)

The Medical Defence Union.

A LOCAL branch of the Medical Defence Union has been formed here. The committee has been well selected, and the names of the gentlemen composing it will command the respect of all concerned. In past years many local practitioners have had to defend actions which ought never to have been brought against them and which probably never would have been had they at once placed their cases in competent hands and assumed a firm attitude. The local defence union deserves, as it will no doubt receive, very hearty support.

American Doctors.

For some time the local papers contained most extraordinary advertisements of American doctors, who were apparently carrying everything before them. After a while the advertisements ceased and one of these "doctors" appeared before the local stipendiary magistrate on a charge of obtaining money by false pretences. The case has been remanded and it is expected that another "doctor" will be charged next week. Any comment would therefore be improper, but it may be stated that the magistrate has expressed his intention to send the case to the Assizes and that he has refused bail.

Liverpool, Nov. 2nd.

NORTHERN COUNTIES NOTES.

(FROM OUR OWN CORRESPONDENTS.)

Newcastle Hospital Sunday Fund.

ON Sunday last the annual collection was made in the churches and chapels of the city for our medical charities. The day was exceptionally fine for the time of the year, so that no one was prevented from going to a place of worship owing to the weather. It is to be hoped, therefore, that there will be no falling off from the previous high record. It is the collections at the factories which give the most concern. These are to be made on the 14th inst., under rather unfavourable auspices. For instance, the long strikes in the spring, and also the fact that the men when they did return to work in most cases went in at reduced wages, must be remembered.

Gift to Sheffield by Mr. E. Bainbridge.

Mr. Emerson Bainbridge, well known in Sheffield in connexion with all philanthropic movements (and whose family in Newcastle is equally known in the same paths), has announced his intention of making a further munificent gift to the town of Sheffield. He proposes to purchase from the Corporation a plot of land near the municipal buildings and to erect thereon a building to serve the purposes of a children's refuge, where all waifs and strays of the town may be sure of shelter, warmth and food. He hopes the Society for the Prevention of Cruelty to Children will take over the building and so, while alleviating the present distress, provide for the future of the children.

Rabies at Scarborough.

It is reported that there is a rather serious outbreak of rabies at Scarborough. The muzzling order is in force and more than a score of dogs have been destroyed.

The Maclagan Fund at Berwick.

A largely attended meeting of subscribers to this fund was held on Monday night last at Berwick, under the presidency of the Mayor. It was agreed that the permanent public memorial to the late Philip Whiteside Maclagan, M.D., should take the form of a statue of Hygeia and drinking fountain, with medallion of the late doctor and suitable inscription, to be erected in the High-street, Berwick. The remainder of the money, about £600, is to be handed over to the daughters of the late Dr. Maclagan.

Odds and Ends.

An explosion of hydrogen gas took place last week at Penrith during a chemistry lecture in connexion with the course started by the Technical Education Committee. The explosion is described as being rather serious, injuring some of the pupils slightly, while the lecturer was so scorched and blinded that he will be unable to resume his duties for about a week.—Mr. Bindloss of Kendal, at a late special meeting of the Corporation of that town, made an offer on behalf of himself and wife to build a new town-hall to be opened on the occasion of their silver wedding in 1894. The cost of the structure will be about £10,000. The present building was shown to be inadequate for the required accommodation for magistrates, police &c., and was of course open to sanitary objections. This generous offer of Mr. Bindloss was duly accepted by the town with thanks.—An unpleasant visitor arrived last week in Carlisle in the form of a tramp with small-pox. It was shown that his journey to the border city was (from Huddersfield, where small-pox existed) by Pateley-bridge, York and Newcastle. He also visited several places the names of which are not known.—Lady Mary Fitzwilliam has been holding a very successful bazaar in Doncaster in aid of ambulance work.—The Mayoress of Hartlepool distributed the certificates and medallions to the large class which had been instructed by Dr. B. Morison. In the report it was stated that 160 students had attended the first-aid ambulance class.—A handsome drinking fountain has been erected near the central station in this city in memory of Richard Grainger, the builder of modern Newcastle.

The Railway Collision near Thirsk.

In reference to the dreadful railway accident which happened this morning, it would appear that at least nine lives have been lost. A great number of persons who have been injured have reached their destinations and so are scattered about the country. Mr. Hartley, surgeon to the North-Eastern Railway at Thirsk, informs me that he has two passengers at the Thirsk Hospital suffering from great shock.

Dr. George M. Murray has commenced a post-graduate course at the College of Medicine, Newcastle, on Bacteriology.

Northumberland and Durham Medical Society.

At the October meeting of this Society several specimens and cases of more or less interest were brought under the attention of the members. Amongst them were the following:—Dr. Robertson showed a man aged sixty-seven, who for twenty years had some difficulty in swallowing. During six weeks before operation very little food could be taken, and most of it was speedily returned. Obstruction was discovered by use of the sound fourteen inches from the lips. Gastrostomy was performed in July. The patient has been fed only by artificial opening since, for no food would go down the normal route. The man is at work daily, and since the operation has gained a stone in weight. The fistula causes no trouble by leakage. Dr. Robertson also exhibited a case of mastoid disease, showing recent methods of operating.—Mr. Black brought forward a case of excision of wrists. The patient, a girl of ten, had been treated by rest for some months, but this failed to arrest the disease. A straight incision (dorsal) was made in the line of the extensor indicis. All the carpal bones, except the trapezium and pisiform, were removed; also the bases of the second and third metacarpal bones and the centre of the end of the radius with the diseased synovial membrane. The result of the operation was entirely satisfactory.—Dr. Drummond showed a case of multiple cerebro-spinal sclerosis. Two points made the case specially interesting—(1) the diagnosis could be made with certainty; (2) the lesion began in the brain, which was rare. The patient, aged thirty-one, somewhat suddenly after an indefinite illness developed slight left hemiplegia. Within a fortnight diplopia followed; later, difficulty in swallowing and slowing of speech. There were now present almost constant movements of head, nystagmus, tremor of hands, rigid lower extremities, with increased knee jerks and ankle-clonus. Dr. Drummond also showed a girl, aged fourteen, suffering from chronic chorea for five years. She has taken arsenic for four years and now shows marked pigmentation of the skin, of a peculiar yellow tint best marked at the root of the neck, round the breasts and about either axilla.—Mr. Rutherford Morison showed a man, aged seventy-seven, the whole of whose lower lip he had excised for epithelioma, and a soldier who was admitted into the infirmary with a compound depressed fracture of the right parietal bone without symptoms. Two hours after the accident he was trephined. A lock of hair was firmly wedged in between the fragments and could not have been dislodged without elevating them. The disc of bone was cut into small pieces with bone forceps, washed well in 1·40 carbolic lotion, and the opening was packed with tus delvis. The wound healed by first intention without drainage. Some disappointment was felt now, for there was a well-marked depression over the trephine hole

evidently from subsequent absorption of part of the new bone, though no portion of the opening is soft. The case was intended to show the advantage of trephining in all compound depressed fractures, for without this it would have been impossible to secure asepsis. — Mr. Rutherford Morison also showed a patient whose vermiform appendix he had removed for recurring attacks of perityphlitis. Three weeks ago the operation was performed, and on examination the appendix was seen to be ulcerated and perforated at one minute spot, where it had fortunately contracted adhesions to the parietal peritoneum on the outer side of the cæcum. The patient recovered in the most uneventful fashion.—Dr. Hume showed a patient who had been operated on for suppurating hydatid of the liver.—Dr. Robertson showed a urethroscope and recommended its use in all forms of urethritis for diagnosis and treatment.—Mr. Rutherford Morison exhibited two ovarian tumours removed from women of the respective ages of seventy-seven and seventy-four.—Dr. Drummond exhibited the liver of a patient admitted to the infirmary moribund with jaundice and acute peritonitis. The post-mortem examination showed both to be due to the presence of an immense hydatid which had ruptured into the peritoneum in the liver.—Mr. Page exhibited a number of gallstones removed by cholecystotomy, and Dr. Murphy a variety of specimens in connexion with the pathology of abdominal organs.

Newcastle-on-Tyne, Nov. 2nd.

SCOTLAND.

(FROM OUR OWN CORRESPONDENTS.)

Edinburgh Improvement Scheme.

THE Edinburgh Town Council, as local authority, have under consideration a provisional Act, to be known as the Edinburgh Improvement (Housing of the Working Classes Act) Scheme. This Act is specially intended to deal with "slum property." It includes provisions for dealing—(1) with unhealthy areas so as to make them efficient for sanitary purposes; (2) the widening of existing approaches to unhealthy areas or for opening out the same for purposes of ventilation and health; and (3) providing accommodation for persons of the working classes displaced in those areas.

Edinburgh University Court.

At the meeting of this court last week the following gentlemen were recognised as teachers whose courses qualified for graduation:—Dr. J. S. M'Laren, in Surgery; Dr. P. H. Maclaren, in conjunction with Dr. C. W. Macgillivray, in Clinical Surgery; Dr. James Hodsdon, in Surgery, in charge of teaching rooms; and Dr. R. F. C. Leith in Pathology.

Edinburgh Royal Medical Society.

The following gentlemen have been elected presidents for the year of this Society:—A. N. S. Carmichael, M.B., C.M.; J. W. Crerar, M.B., C.M.; Line Boorn King, M.B., C.M.; and Harry Rainy, M.A., M.B., C.M.

Leith and Public Health Matters.

There is at present in Leith not only an epidemic of measles and scarlet fever, but there has also been an outbreak of typhus fever. The result is that there has been a greater demand for hospital accommodation than the burgh possesses, and the authorities have had to erect temporary structures. The authorities have had under consideration a site for their infectious diseases hospital which seems to be acceptable. There are six acres of ground, and the price is said to be £600 per acre. A suspicious case of illness from a steamer from Hamburg has been admitted into the observation wards, but no definite opinion has been pronounced as to its nature. The local authorities are again engaging the attention of the Board of Supervision. It appears that the Sanitary Association of Scotland has written to the board complaining that the person appointed sanitary inspector to the burgh was not a member of their Association and that he had no practical knowledge of the work of such a post. The board has transmitted this letter to the local authority.

Health of Edinburgh.

The mortality last week was 87, making the death-rate 17 per 1000. Diseases of the chest caused 20 deaths and zymotic diseases 30, of which 4 were due to diphtheria, 3 to scarlet fever and 21 to measles. The intimations for the week were: typhoid fever, 4; diphtheria, 4; scarlet fever, 75; and measles 380.

General Council of the University of Edinburgh.

The statutory half-yearly meeting of this body was held last week, Sir William Muir being in the chair. There was only a small attendance. The business included the order by Her Majesty in Council continuing the powers of the Universities Commissioners until Jan. 1st, 1894, and the intimation that certain ordinances, including some dealing with the medical faculty, had been approved by Her Majesty in Council. The report by the Committee of Council on Ordinances, which was submitted, dealt in the first place with the remit from the April meeting to promote an address from the House of Commons for reconsideration of certain ordinances. It traced the steps which the committee had taken and the result of the deputation to London, and the causes which led to the motion for reconsideration being defeated in the Commons. The statement made by Sir Henry Roscoe in the course of the debate in the House, that it was the intention of the Commission to make such an arrangement that the professors would be entirely independent of the fees of their own classes, and that there would be a fee fund, with a minimum salary fixed for each professor, was regarded by the Committee as a change which might be far reaching in its effect. It was looked upon as the admission of a new principle which would remove one of the chief obstacles in the way of reforms which had already been urged by the Council. The other reports submitted to the meeting were of no medical interest beyond the fact that the medical curriculum is taken as the type on which other departments in the University ought to be modelled.

Health of Aberdeen.

Last week 503 cases of zymotic diseases were reported to the medical officer of health, including 454 cases of measles, 36 of scarlet fever, 8 of erysipelas and 1 of typhoid fever. On the whole, there was an increase of 68 cases on the number for the previous week.

Aberdeen University: Assistant Professorships.

The following appointments were announced at a meeting of the University Senatus last week:—Mr. George Dean, M.A., M.B., C.M., to be Assistant to the Professor of Pathology; Mr. Alexander MacGregor, M.D., to be Assistant to the Professor of Practice of Medicine; Mr. Robert Gordon Mac Kerron, M.A., M.B., C.M., to be assistant to the Professor of Midwifery; and Mr. J. Wemyss Grant, M.B., C.M., to be Second Demonstrator of Anatomy.

Aberdeen Medical Staff Corps.

Last week the 7th (Aberdeen University) Company, Volunteer Medical Staff Corps, held a highly successful smoking concert, Surgeon-Captain MacGregor presiding. He reviewed the work of the year, and intimated that financially they had a good balance in their favour. The prizes for drill and best kept tents were then distributed.

Aberdeen: Death of Dr. John Urquhart.

We regret to announce the death of Dr. Urquhart after a long illness of nearly three years' duration. Dr. Urquhart, who was sixty-six years old, after studying at Aberdeen and Edinburgh Universities, graduated M.D. Edin. and afterwards obtained the M.R.C.S. Eng. He practised for twenty-two years in Madras, where he was coroner and professor of medical jurisprudence, and where he acquired a large practice. Returning to Aberdeen in 1870 he soon became known as a leading practitioner, and for long has been affectionately regarded as one of the fathers of the profession. He took a keen interest in all benevolent and philanthropic work, and was many years a manager of the Royal Infirmary, of the Lunatic Asylum and of the Public Dispensary. In the affairs of the local medical societies he was deeply interested and held office on the management of several. His funeral was attended by practically the whole of the medical profession in Aberdeen and by most of the leading citizens.

Glasgow Obstetrical and Gynæcological Society.

Officers for ensuing session:—Honorary President, Sir Spencer Wells, Bart.; President, Robert Pollok, M.B.; Senior Vice-President, G. A. Turner, M.D.; Junior Vice-President, Thomas Richmond, L.R.C.P.Edin.; Treasurer, Alex. Miller, L.R.C.P.Edin. &c.; Secretary, J. Nigel Stark, M.B.; Reporting Secretary, Robert Jardine, M.D.; Pathologist, A. Milroy, M.D. Council—Robert Kirk, M.D.; H. St. Clair Grey, M.D.; Malcolm Black, M.D.; E. H. L. Oliphant, M.D.; A. Richmond, M.B.; and D. N. Knox, M.D.

IRELAND.

(FROM OUR OWN CORRESPONDENT.)

Increase of Lunacy in Ireland.

FROM the last report of the Inspectors of Lunacy, it appears that the number of lunatics under care has increased from 249 per 100,000 of the population in 1880 to 355 per 100,000 in 1891. Such an increase is a matter of grave concern. The large number (3,415,400) of people who have emigrated during the past forty years—tending to remove the healthy and strong both in mind and body, thus leaving a large number of the weak and infirm as a burden on the public rates—must be considered as one of the chief factors of this large increase. Hence it may be assumed that the present number of the insane in Ireland properly belongs to a much larger population than that which now exists. But making full allowance for this cause, which tends to show an apparent increase of insanity, it must be concluded that the large increase of lunacy has been absolute as well as relative. The rapid increase of insanity with a diminished population, the inspectors remark, ought to engage the attention of all who take an interest in the social and material progress of Ireland, in order to ascertain how far such increase can be stayed by any means within the power of the State.

Grievances of Dispensary Medical Officers.

A meeting of the Irish Poor-law Medical Officers' Parliamentary Committee was held last week, when the following resolution was adopted unanimously: "The members of the Irish Poor-law Medical Officers' Parliamentary Committee express their sincere regret that the Right Hon. John Morley, Chief Secretary for Ireland, declined to receive the deputation from the conjoint associations which was appointed to wait on him with reference to the questions of superannuation and the other admitted grievances of the dispensary medical officers, and, whilst deprecating any intention to inconvenience the Government in its work of legislation in the coming session, yet hope that the Government will give every facility to have the Bills submitted to the judgment of the House of Commons when introduced by private members."

Royal University of Ireland.

On the 29th ult. degrees were conferred by the President of the Queen's College, Galway, in the absence of the Chancellor and Vice-Chancellor. Among those present was his Excellency Lord Houghton. The candidates who entered for the various examinations during the year numbered 2857, showing a decrease of 27 as compared with last year, while there were 201 degrees conferred. A conversazione of the graduates, undergraduates and guests was held the same evening in the University buildings. A concert, military band, experiments in biological science and lantern slides illustrating the Arran Islands added to the attractions of the evening.

Health of Dublin: September Quarter.

The births registered amounted to 2441 and the deaths to 2010, or 23 per 1000, being 0·5 below the average for the September quarter of the past ten years. Zymotic diseases caused 323 deaths, or 97 over the number for the corresponding quarter of last year. Deaths from measles fell to 59, while scarlet fever only caused 5 deaths, typhus fever 1, ill-defined fever 2, and typhoid fever 21.

Schools of Surgery: Royal College of Surgeons.

On Tuesday last the distribution of medals and prizes awarded during the past session took place. Mr. Hamilton, President of the College, said that the Council had done everything that careful inquiry and expenditure of time and money could do to make the schools of surgery perfect and a credit to the College, but without the coöperation of the students their efforts would have been futile. An attempt had been made to transfer from the professors in Dublin the teaching of medicine and surgery. He would leave the professors to stand on their own record, and he thought when they came to be weighed in the balance they would be found equal to those who would fain supplant them. The important question for everyone concerned, medical men and the public alike, was whether the movement he had referred to would be for the benefit of the hospitals themselves. He thought it would not. A fifth year had lately been added to medical study, and with all due deference to the General Medical Council he believed that it was a great mistake. He wished the Council had rather turned their attention to a really weak link in the system—namely, preliminary education. He felt satisfied that the boy who had been thoroughly trained would grasp more of his medical studies in four years than he would under the present system in six years. But the boy must be trained, not crammed, and what was wanted was a good boarding school, where boys, on moderate terms, could have a training which would fit them for entering schools of surgery and medicine.

Mr. J. Kellock Barton, ex-President and Member of Council of the College of Surgeons, has resigned his seat as Councillor. Mr. F. T. Heuston will be a candidate, and the names of Mr. Swan and Mr. Humphrey Broomfield are also mentioned.

Nov. 1st.

PARIS.

(FROM OUR OWN CORRESPONDENT.)

Medical Treatment of Rectal Cancer.

THE question of medical treatment of cancer of the rectum, in contradistinction to surgical procedure, is an interesting one, seeing that the latter is of so little promise in many cases and that a very short immunity only from recurrence is obtained after running the gauntlet of a severe surgical operation. For such cases, where the disease is advanced and the progress slow, M. Dujardin-Beaumetz has devised a plan of treatment of which he reports favourably and which he credits with being able to prolong the patient's life longer than could be hoped for after an operation, even when successful. With this end he has recourse to intestinal washings with antiseptic solutions, so as to arrest, or at least diminish, the progress of the malady by removing the pus and secretions frequently. A solution of naphthol—ten to twenty centigrammes per cent.—is what he advises. In addition to this he disinfects the intestinal canal by exhibiting salol or benzo-naphthol with bicarbonate of soda, in wafers by the mouth. Laxatives must also be given to prevent any accumulation in the colon, and M. Beaumetz is of opinion that a diet consisting largely of vegetables is also advisable. He has at present under observation three patients suffering from rectal cancer who for the last three years have been subjected to this method of treatment and who have even gained in flesh. He is satisfied that the method is superior to extirpation.

Monopolies versus *Therapeutics.*

France is the country *par excellence* of monopolies and commercial or industrial protection. Every visitor to *la ville Lumière* knows how these overshadow the common necessaries and ordinary conveniences of life—such, for example, as in the matters of water, gas, lucifer matches, tobacco and cigars, omnibuses &c.—and the citizen of this enlightened republic of vaunted liberty, equality and fraternity is reduced to Hobson's choice. He must have what is provided for him by the powers that be or go without; the alternative provided by healthy competition is out of the question. It will scarcely be credited, however, that this system of monopoly and exclusiveness extends to the domain of therapeutic agents; and yet it is so. For instance, the market is flooded with an endless variety of French mineral waters—a few good, others bad, but the great majority indifferent. Foreign competition is discouraged by interested persons and influential companies, and vexatious obstacles and delays are thrown in the way of the introduction of any foreign mineral water—where, indeed, this latter is not altogether excluded. I have had an instance of this recently in my own practice. I ordered a patient suffering from gout a German mineral water which is being largely prescribed in such cases by my teachers, the physicians of the British school, but was unable to procure the water, as its sale was unauthorised in France! Where, however, foreign water is long and universally recognised to be unequalled by any French production of its kind, it is admitted, on sufferance, with attached conditions. Of course, successful springs have their French competitors and allies, the chemical composition of which may bring them into apparently close therapeutic relationship. But, as has been well pointed out by Sir Henry Thompson, a like chemical composition by no means implies a like therapeutic effect.

Insanitary Kitchens in Paris.

Foreigners who enjoy the occasional luxury of a dinner at a fashionable Paris restaurant little dream of the unhealthy, not

to say disgusting, surroundings of the myrmidons whose duty it is to prepare the appetising viands sent upstairs. A peep at the kitchen in too many celebrated establishments would assuredly have the effect of dispelling the appetite of even a burly Yorkshire farmer. That I do not exaggerate is abundantly proved by the report just made to the Conseil d'Hygiène de la Seine by M. Deschamps. This report is based on the investigations of Drs. Calendreau and Regeard, medical officers to the Société des Cuisiniers de Paris. Dr. Regeard says of these kitchens that they are, in fact, the foulest rooms in the house—airless, because the ventilators are kept closed in order to avoid odours in the dining-rooms and in neighbouring houses; often also deprived of any other than gas light. The waterclosets are generally in direct communication with the kitchen, and, in many instances, access to them being forbidden during the busy hours of the day, the cooks are compelled to utilise preserved fruit and vegetable boxes as urinals. All the above details are sufficiently disgusting to the customer, but the report would be incomplete were no reference made to the disastrous effects of these insalubrious conditions on the health of the men who pass their lives in these dirty holes. Dr. Calendreau tells us that, in addition to infirmities such as varicose veins, varicocele and hernia, which are peculiar to the calling, cooks suffer from the following maladies: (1) Rheumatic pains from damp, absence of fresh air and light; (2) sore-throat and bronchitis, due to exposure to draughts and excessive heat, with consequent indulgence in iced beverages; (3) dyspepsia and alcoholism; and (4) pulmonary phthisis. The foregoing list explains the high mortality prevailing amongst this numerous class. The remedy proposed for this deplorable state of things is as follows: No restaurant kitchen to have dimensions less than, length, 3 metres; breadth, 2 metres 50 centimetres; height, 2 metres 80 centimetres; every kitchen to be independent for air and light of small courtyards; the kitchen to be separate from the scullery; the floor to be waterproof; the larder to be isolated; urinals and closets to be quite apart from the kitchens; the suppression of bedrooms in proximity with the kitchens. The Municipal Council has had the above reforms under consideration, and we shall, I trust, soon see them put into execution.

Paris, Nov. 2nd.

VIENNA.

(FROM OUR OWN CORRESPONDENT.)

Cholera in Austria-Hungary.

AT the time when the first case of Asiatic cholera was admitted to the Hospital for Epidemic Diseases, two other suspected cases were brought there in which the presence of the comma bacillus could be proved. One of these died on Oct. 28th, and after a post-mortem examination the case was pronounced to be one of Asiatic cholera. The patient was a boatman who had arrived at Vienna, on the day of his admission to the hospital, from Hungary, on board a ship belonging to the Danube Regulation Company. The other case in which the comma bacillus was also found was that of a labourer who had worked on the Danube embankment, and who had been infected, as is supposed here, by carrying infected linen and rags which were unloaded here from Hungarian boats. He is now recovering. No other cases of real cholera have occurred in Vienna since these three cases have come under observation, though eight to ten suspected cases of intestinal diseases were sent daily to hospital by anxious physicians. This choleraphobia among the physicians—which proved sometimes very serious to the patients from a social point of view, as their lodgings and shops were put under quarantine—is due to the fact that the younger generation of physicians have had no opportunity of seeing a case of cholera during their medical practice, and older physicians who have been in active practice during a cholera epidemic ought to have been appointed by Government to examine these suspected cases. The official return issued by the Upper Medical Council states that up to Oct. 28th 136 cases of cholera have occurred in Austria since the outbreak of the disease—130 of them in Galicia and Cracow and its environs. No official report on the statistics of the number of deaths from cholera in Hungary has appeared as yet, but the daily number of cases at Budapest and in the provinces may be estimated as between 30 and 40.

Vienna, Oct. 31st.

NEW YORK.

(FROM OUR OWN CORRESPONDENT.)

Cholera and Quarantine.

THE recent public excitement over the appearance of cholera at quarantine has entirely subsided. There is now neither cholera at quarantine nor in the city. The experiences of many prominent citizens at quarantine are destined to have an important influence upon future legislation. Hitherto it has been very difficult to impress public men with the deficiencies of our quarantine system and obtain needed reforms. But now senators, clergymen, physicians, lawyers and newspaper men have been caught in our quarantine trap, and compelled to endure not only all the inconveniences, but all the hardships, and even perils, which our quarantine imposes upon the luckless traveller. Whatever may be the shortcomings of the health officer—and they are doubtless many,—there are glaring defects in our quarantine which it is to be hoped will now be remedied. Perhaps the most important defect is inadequate space for the purposes of a modern quarantine. The extreme accommodations of the establishment are for 750 persons, and yet there were upwards of 4000 people at one time demanding immediate removal from infected ships and isolation in proper quarters for their care. It was impossible to meet this emergency at once and hence the hardship of detention on board ship. The condition was the more alarming to cabin passengers inasmuch as they were ignorant of the fact that cholera prevailed among the steerage passengers until the ships were anchored in the bay, within sight of the city. Then they learned that they were on cholera-infected ships, and that they must remain from five to twenty days after the last case had appeared, as there was no possible method of accommodating them within the quarantine grounds. What added to the excitement was the constant occurrence of new cases among the steerage passengers and the danger that the infection would reach the cabin or first-class passengers, so impossible was it to cleanse and disinfect in the presence of crowds of passengers. Hundreds of men and women who had braved the perils of the sea found themselves within sight of home, helpless in the presence of an increasing and threatening pestilence. Public excitement became intense, meetings were held and committees appointed to rescue them. One citizen purchased a steamboat for $30,000 and sent it to their relief. An appeal was made to the General Government to create a camp on Sandy Hook, to which the healthy passengers could be removed. The Government responded promptly, but it required time to erect and provision a camp. The Governor also came to the rescue and purchased Fire Island, a summer resort, and turned it over to the health officer. The Chamber of Commerce raised a relief fund of $250,000. But all these measures were destined to fail to give prompt relief. The steamboat proved to be almost uninhabitable, as it was out of repair and unseaworthy. The passengers who were removed to it found their discomforts increased, and though they had escaped the risk of contracting cholera, they now incurred the dangers of fire and water. Those passengers who were conveyed to Fire Island were in still greater perils. They had a voyage of forty miles on the open sea in a small river craft unprovided with such common furniture as chairs, beds &c. During the passage, which was made at night, a storm arose which threatened the frail vessel with its 250 passengers. When it reached its destination the pilot could not find the channel to the bay, and the vessel had to return to the New York harbour in the teeth of the storm. Travellers report that they never experienced such hardships by sea or land. Old people and children suffered intensely, but happily no deaths occurred. On the following morning the vessel was ordered to return and the wretched passengers, sick and suffering and without food, had to endure the third perilous voyage over the rough sea. The close of this last trip witnessed a scene which might well have occurred on the coast of Africa. The vessel passed into Great South Bay with its human freight in the last stages of suffering for the want of food and from the incessant exposure to the hardships of the three voyages. As they approached the island they were met by men in boats, who not only refused to allow them to land, but even forbade them being supplied with food. Strong men earnestly appealed to these inhuman wretches to provide food for sick children and old people, but they not only refused, but one man waved a loaf of bread

upon a pole to tantalise the sufferers. Relief came only when, under the orders of the Governor, the military took possession of the island. The camp at Sandy Hook was finally completed and the steerage passengers were removed to it, thus relieving the steamships of their inhabitants. The difficulties of quarantine were complicated by an outbreak of measles among the children of the immigrants, which assumed large proportions. The cases of cholera, however, diminished rapidly and soon ceased to recur. At the close of the month the harbour was free from cholera.

October, 1892.

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

MEETING OF FELLOWS AND MEMBERS.

THE annual meeting of the Fellows and Members of the Royal College of Surgeons of England was held on Thursday in the theatre of the College. There was a fair attendance.

Mr. THOMAS BRYANT, President of the College, occupied the chair. In the course of his opening remarks he said that this was the ninth consecutive annual meeting of the Fellows and Members of the College, and it would be gratifying if, when the meeting was over, they could all come to the conclusion that it had been of advantage to the Fellows and Members and to the credit of their great institution. The report which the Council had presented was a complete epitome of the work of the past collegiate year. It contained everything that could be of any interest to the Fellows and Members. The curriculum of study had been carefully and fully considered and the Fellows and Members of the College might look upon the scheme as complete and well considered. There was little to be said about the new university for London, for the question was now under the consideration of a Commission. At present the College had nothing to do with it; they had given evidence before the Commission and they were considering the evidence as it went on. He need hardly say that probably when the proper time came, they might sketch out some sort of scheme, which probably would be laid before the Fellows and Members. As to the further advantages conferred on Fellows, he would say that it had been gratifying to the Council to feel that their hands were comparatively free in the matter, and he hoped they would be able to hear on this occasion that the Fellows were fairly satisfied with what the Council had done. There was an amusing mistake in the report. It was stated that during the past year the Council had had under their consideration two cases of misconduct by "Members of the Council" in which they had inflicted the penalty of removal. There was something rather humorous in this, but of course it meant "the Members of the College." He thought the meeting would agree with the Council in seeking to purge the College of any men who had transgressed the law of the land. Whenever their attention was called to any act of any Member of this College which they considered prejudicial to the interests or derogatory to the honour of the College, or disgraceful to the profession, they wrote and asked whether such and such an advertisement or statement was true or not, and when necessary they assured the man that such conduct was against the declaration he made when he became a Member of the College. They had good reason to believe that in this way they had obtained most excellent results. As to the museum, he might say that the extraordinary expenditure in connexion with it had come to an end and they had paid the last cheque, and he thought they had got their money's worth. As to the library, he did not think they had anything to say in the way of fault-finding. It was certainly the most satisfactory library for working in anywhere in the world. The finances of the College were in a satisfactory condition and the Council contemplated the future without anxiety.

The Assistant Secretary intimated that notice of the following resolution had been given by Mr. Lawson Tait and Mr. Nelson Hardy—viz., "That this meeting of the College of Surgeons of England is of opinion that the report now presented is ineffective and incomplete, and this meeting is further of opinion that the ancient attitude of hostility on the part of the Council to the true interests of the body corporate of the College ought to terminate, and that the repeated resolutions passed at former meetings of this College should be carried into effect."

The President suggested to Mr. Lawson Tait that the resolution should be divided in two. He might have been pleased perhaps if he had felt it fully expedient to say that this resolution should not be submitted to the meeting. He need hardly say that it had a sting of an offensive character in it which was not quite consistent with the good feeling with which he hoped they had all met. He would be glad if the proposer and seconder and their supporters saw their way to withdraw the resolution. (Cries of "No, no.") At any rate, the meeting had heard the resolution read, and he thought it would be wise to put to the meeting the question whether the resolution should be put. He would prefer the meeting to say that it should not be put.

Mr. Lawson Tait: You cannot do that until your hear the matter argued.

The President: The first part may be put. We do not recognise an "ancient attitude of hostility" on the part of the Council.

Mr. Lawson Tait: But we do, which is the whole thing.

The President, continuing, said the resolution quietly suggested that the Council of the College was not acting in the true interests of the body corporate. If that was an expression of opinion the Council would take it for what it was worth and let it go on. It was an extremely offensive resolution, and he was very sorry it should be before the meeting. He ruled that it be divided.

Mr. Lawson Tait said he knew of no meeting conducted in such an extraordinary fashion as this. He had never heard a chairman argue a resolution before the opener had spoken, and he had never heard of any business body in this world begin a meeting as this meeting had been begun.

The President invited Mr. Lawson Tait to address himself to the resolution.

Mr. Lawson Tait said he would do that in good time. For the present he would give reasons why the resolution should be considered as a whole and not divided. The resolution had been accepted by the secretary in the course of correspondence that had taken place on the subject. If it must be altered he considered that there had been a breach of bargain. He would submit, however, to the division of the resolution. He denied that there was anything offensive in it. Less offensive words than "ineffective and incomplete" could not be used. The report was incomplete for this among other reasons—that it gave no sufficient information with regard to the question of a new university for London. As to the curriculum of study, it did nothing for the student except to give him an additional year of study. While good enough so far as it went, it was manifestly the work of academic men who soared in the clouds above the wants of the medical profession of the day. Had there been on the Council Members of the College engaged in general practice the scheme of study would have been very different indeed. He begged to move: "That this meeting of the College of Surgeons of England is of opinion that the report now presented is ineffective and incomplete."

Mr. Nelson Hardy, seconding the resolution, said the report should not merely be presented, but should be open to correction and, if necessary, to rejection. From the statement of the President himself it would appear that at least one matter in the report required correction.

Mr. George Brown supported the resolution mainly on the ground that the report lacked the information about the university scheme to which he thought the Fellows and Members entitled.

Mr. Craven (Hull) said he did not take this gloomy view of the situation. He knew of no college better managed than this. No one could bring a word of complaint against the management. To this opinion he adhered, in spite of what others might say to the contrary.

Dr. Danford Thomas spoke in support of the resolution.

Mr. Square (Plymouth) moved as an amendment, "That this meeting respectfully begs that the report be referred back to the Council for reconsideration, to be brought up again at an adjourned meeting."

The President: I cannot put that. It is not in the power of this meeting.

Surgeon-Major Ince said he found himself in the midst of a body of fighting men, although he himself was not a fighting man. He begged to move, "That this meeting regards this report as satisfactory, and acknowledges the liberality of the Council."

This motion was ruled out of order.

Mr. Holmes said he did not intend voting on the resolution. He recognised in the report a very great deal which he thought would be for the benefit of the Fellows.

A show of hands was then taken, when 10 persons voted

for the resolution and 16 or 17 against it. The resolution was accordingly lost.

Mr. Lawson Tait then moved the second part of the resolution, namely: "And this meeting is further of opinion that the ancient attitude of hostility on the part of the Council to the true interests of the body corporate of the College ought to terminate, and that the repeated resolutions passed at former meetings of this College should be carried into effect."

Dr. Alderson seconded the resolution.

Mr. Joseph Smith said he wished to clear up a misapprehension about the costs in the recent litigation. The College had asked for its costs and it would get its costs. He and his friends expected nothing gracious from the College in this matter.

Surgeon-Major Ince urged Mr. Lawson Tait to withdraw the resolution, saying that he ought to be gentle and forbearing to the Council. Let them conclude the meeting in a peaceful and friendly manner.

The President before putting the resolution to the meeting said that he supposed it would be useless for him to assure Mr. Lawson Tait and his friends that if there ever was any "ancient hostility" on the part of the Council, there was none now. The Council were doing their very best for the body corporate.

The resolution was carried by twenty-five votes to ten.

Mr. Holmes, on behalf of the Association of Fellows, moved: "That this meeting of Fellows and Members desires to thank the Council of the College for acceding to their wishes in the matters (*a*) of separate meetings of Fellows and Members, and (*b*) of the provision of a Common Room in the College."

Dr. Danford Thomas seconded the motion and it was carried with only one dissentient, namely, Mr. Lawson Tait.

Mr. F. Gant moved, also on behalf of the Association of Fellows: "That this meeting of Fellows and Members wishes again to impress upon the Council that it is absolutely essential for the welfare of the College that the Fellows and Members should be consulted before any change is made in the constitution and external relations of the College and before the College is committed to any extraordinary expenditure on buildings or otherwise."

The President explained that the Council had had this matter under their consideration on many occasions, and there was a kind of undertaking between them that in any important change in the constitution of the College they should consult the Fellows and Members.

Mr. Joseph Smith seconded the motion.

Mr. Lawson Tait asked for information about the undertaking of which the President spoke.

The President said that as long ago as Nov. 17th, 1885, the Council, after considering certain resolutions passed at a meeting of Fellows and Members, agreed, "That with the larger questions which more rarely arise, such as those which concern the constitution of the College, the course will be different. Upon those questions the Council will always be glad to have an opportunity, so far as practicable, of consulting the Fellows and Members."

Mr. Lawson Tait said he had seen no disposition on the part of the Council to take advantage of this resolution.

The President reminded him that there had been meetings in connexion with the expenditure upon the museums and the university question.

The resolution was carried by 22 votes to 2.

A vote of thanks having been accorded the President the meeting terminated.

A FREE GIFT.—Abington Abbey together with twenty acres of land has been offered to the Northampton Town Council for use as a people's park by Lord and Lady Wantage.

A NEW MEDICAL SOCIETY.—A new society has been started in Oxford for the discussion of subjects connected with medicine and surgery. The first meeting is to be held on Nov. 11th, when Sir James Paget will deliver an inaugural address. Sir Henry Acland has been chosen as the first President, the vice-Presidents being Professor Burdon-Sanderson and Mr. Alfred Winkfield, Dr. Collier acting as secretary and treasurer. The ordinary meetings of the Society will be held on the second Friday in each month.

Medical News.

ROYAL COLLEGES OF PHYSICIANS OF LONDON.—The following gentlemen having conformed to the by-laws and regulations and passed the required examinations were at the quarterly meeting of the College admitted Licentiates:—

Alston, H., University College.
Anderson, C. M., Edin. and Guy's.
Atchley, E. G. C. F., Bristol.
Attainson, H. N. C., St. Barthol.
Auty, C. H., St. Bartholomew's.
Badham, R. C., Sydney & London.
Bailey, Thos. Wm., Westminster.
*Baldwin, Henry Clifford, Leeds.
Barnard, Harold Leslie, London.
Beckitt, James Clay, Glasgow.
Bensusan A. D., St. Thomas's.
Bernard, Claude, Bristol.
Brabant, R. H. W. H., Guy's.
Bradshaw-Isherwood, Percy A., St. Bartholomew's.
Brasher, Chas. Wm. Jas., Bristol.
Brisley, Chas. W., St. Thomas's.
Bryant, Hugh Arnold, Guy's
Buck, Arthur H., St. Barthol.
*Bury, Reginald F., St. George's.
Campbell, J. A. L., Westminster.
Carter, Hugh Ronald, St. Mary's.
Cartwright, Ernest H., Oxford and Guy's
Clarke, Hugh C. W., Manchester.
Colmer, Ptolemy A., London.
Cook, Fredk. Ernest, Liverpool.
Cooper, Dossabhoy N., Madras and St. Bartholomew's.
Covey, W. J., University College.
Creswell, Frank P. S., Guy's.
Crofts, George Harry, Liverpool.
Crosland, Geo. Wm. K., Leeds.
Dixon, Thomas, Birmingham and St. Mary's.
Duka, Albert T., Camb. Univ. and St. George's.
Dutton, Arthur S., St. Thomas's.
Edwards, G. M., Camb. & Middlx.
Elliott, Harry Scott, St. George's.
Evans, James Arnold, Liverpool.
Fawssett, Rupert, St. Thomas's.
Fleury, Charles Marlay, Guy's.
Floyd, Stephen George, Guy's.
Foulkes, Thos. H., St. Barthol.
Fraser Luckie, H. O'Naghton, St. Bartholomew's.
Furnivall, P., St Bartholomew's.
Gains, John Edwin, Leeds.
Gardner, Harold, Charing-cross.
Gilbert, Charles William, London.
Gillbard, Richard, Guy's.
Goldsmith, Geo. H., St. George's.
Goodwin, Edwd. K., King's Coll.
*Gover, Lawford D., St. Thomas's.
Grace, Gerald, Bristol.
Green, S. F. St. Davids, St. Barth.
Gregar, Charles Granville, Guy's.
Harding, H. W. L., St. Barthol.
Hawkins, Edwd. J., St. Barthol.
Hayes, Geo. C., King's Coll. and Melbourne.
Henry, Edwin, St Bartholomew's.
Hepton, J. C., Manchester & Glasg.
Heywood, Thomas, St. Mary's.
Hicks, Thos. Wm., St. Thomas's,
Hine, Alfred E., Charing-cross.
Hodgins, W. W., University Coll.
Hollings, Edwin Thomas, Leeds.
Hooper, G. H. J., Charing-cross.
Huntley, Edgar, Guy's.
Jago, Ashley Filsted, Guy's.
Jeaffreson, G. C., University Coll.
Johnson, Lawrence A., Leeds.
Jones, Geo. David E., Middlesex.
Jones, Geo. Reginald, Liverpool, Keele, David, University College.
Kendall, N. F., St. Barthol.
Kendrick, Horace H., London.
Kingsford, B. H., St. Thomas's.
Knightley, W. R., St. Barthol.
*Kobla, D. H., Bombay & Middlx.
Leumann, B. H. F., St. Barthol.
Levy, Alfred G., University Coll.
Lewis, Fredk. H., St. Barthol.
Lister, Thomas David, Guy's.
Lucas, William F., Middlesex.
MacPhail, John A., M'Gill Coll., Montreal, and London.
Marson, F. H., Durham & Birm.
Maw, H. T., St. Bartholomew's.
Meade-King, R. L., St. Barthol.
Merewether, A. E., Durh. & Lond.
Minton, A. H., King's College.
Nankivell, B. W., Middlesex.
Newton, Isaac, Charing-cross.
*Newton, R. F. H., St. George's.
*O'Ferrall, E. F., Charing-cross.
Palmer, C. S., St. Bartholomew's.
Paterson, Hugh Gordon, Leeds.
Paterson, H. John, St. Barthol.
Parry, T. W., Camb. & St. George's.
Perram, E. A., St. Barthol.
Planck, Charles, St. Thomas's.
Quennell, Arthur, St. Barthol.
Redpath, W., St. Thomas's.
Roberts, H. Wm., St. George's.
Roberts, Sydney John, Guy's.
Robinson, Frederick A., Guy's
Robinson, Geo. Burton London.
Robinson, Waring, Middlesex.
Romer, R. Leslie, St. George's.
Rooke, Ernest Morley, Guy's.
Rubra, Henry H., Birmingham.
Scott, Francis Gilbert, London.
Shillitoe, Alfred A., St. Barthol.
Smith, Reginald, Manchester.
Smith, T. R. H., St Barthol.
Stanton, Jas. Wm. W., London.
Stokes, Whitley, St. Thomas's.
Thomas, J. Morgan M., Bristol.
Thorne, Attwood, St. Mary's.
Tootal, John H., St. Barthol.
*Turnor, Philip W., St. George's.
Vincent, Thomas S., Birmingham.
*Walker, E. G. A., St. Barthol.
*Walker, Hyde Edwards, London.
Webb, Cholmondeley, St. George's.
White, Herbert G., St. George's.
White, William, Middlesex.
Wilkes, Geo. A., Birmingham.
Wilkinson, Sidney, Liverpool.
Williams, E. M., St. Barthol.
Williams, R. H., University Coll.
Wilson, Norman O., St. Barthol.
Woodcock, A. H., St. Thomas's.
*Worrall, Chas. Lloyd, Middlesex.

* Candidates who have not presented themselves under the Regulations of the Examining Board.

CAMBRIDGE UNIVERSITY.—At a congregation held on the 27th ult. the following medical degrees were conferred:—

Bachelors of Medicine and Bachelors of Surgery—Augustus Moore Daniel, Trinity; Edward Baines and Sidney Edward Barrett, Gonville and Caius.

LITERARY INTELLIGENCE.—A new weekly Russian medical journal has just appeared under the title of *Yuzhno-Russkaya Meditsinskaya Gazeta*, or South Russian Medical Gazette. It is published in Odessa and serves as the organ of the Odessa Medical Society. The first number contains an article by Prof. Mechnikoff on Present Tendencies in the Treatment of Infectious Diseases and one by Dr. Starkoff on International Precautions in Turkey and Egypt against the Entry of Cholera into Europe from India, together with abstracts from other journals, the Society's proceedings, and general medical news.

MEDICAL MAGISTRATES.—Mr. Henry Aldred, L.R.C.P. Irel., M.R.C.S., of Manchester, Dr. George Herbert Pollard of Southport, and Dr. Edward Sword Morley of Blackburn have been placed on the Commission of the Peace for the city of Manchester and the boroughs of Southport and Blackburn respectively.

FOOTBALL CASUALTIES.—A youth while playing a game at Dalby on the 22nd ult. fractured his femur. The following casualties occurred last week:—During a match at Badsley Moore-lane a member of the Rotherham Thursday team "broke his ankle." In a match between the Small Heath and Darwen teams a member of the former team sustained a fracture of the leg and was admitted to the Queen's Hospital. Whilst playing a game with Repton School one of the full backs of the Derby County Team fractured his clavicle. At Cambridge, in a match under Association rules, a player sustained a compound fracture of his left leg.

ROYAL ACADEMY OF MEDICINE IN IRELAND.—The following office-bearers have been elected for the ensuing year:—President: George H. Kidd. General secretary: William Thomson. Secretary for foreign correspondence: J. W. Moore. Medical Section—President: Walter G. Smith. Council: Wallace Beatty, T. Hawtrey Benson, M. A. Boyd, E. M'Dowel Cosgrave, J. Magee Finny, Richard A. Hayes, J. W. Moore, A. N. Montgomery, G. P. L. Nugent and H. C. Tweedy. Surgical Section—President: Edward Hamilton. Council: Kendal Franks, F. T. Heuston, John Lentaigne, Austin Meldon, Thomas Myles, Edward Stamer O'Grady, Sir W. Stokes, W. Thornley Stoker, R. L. Swan and W. I. Wheeler. Section of Obstetrics—President: A. J. Horne. Council: L. Atthill, Robert W. Flynn, R. H. Fleming, F. W. Kidd, J. L. Lane, S. R. Mason, T. More Madden, R. D. Purefoy, A. J. Smith and W. J. Smyly. Section of Pathology—President: C. J. Nixon. Council: A. W. W. Baker, A. H. Benson, H. Bewley, J. Magee Finny, Edmond J. MacWeeney, J. O'Carroll, R. G. Patteson, J. M. Purser, J. A. Scott and J. B. Story. Section of Anatomy and Physiology—President: H. J. Broomfield. Council: A. Birmingham, H. St. J. Brooks, D. J. Cunningham, E. L. Ledwich, H. C. Earl and Alec Fraser. Section of State Medicine—President: E. M'Dowel Cosgrave. Council: Thomas Donnelly, Edgar Flinn, Ninian Falkiner, T. W. Grimshaw, J. W. Moore and J. M. Redmond.

BEQUESTS AND DONATIONS TO HOSPITALS.—The late Mr. William Baker of South Retford bequeathed £100 to the Retford Dispensary and Cottage Hospital.—Mr. Josiah G. Strachan, late of Farmhill Park, near Stroud, bequeathed £1000 to St. Mark's Hospital for Fistula, and £500 each to the British Hospital for Diseases of the Skin, the Cancer Hospital, Brompton, and the Central London Throat Hospital.—The workmen of Sir W. G. Armstrong, Mitchell and Co., at Elswick, have contributed £270 9*s.* 10*d.* to the local medical charities for the quarter ending September last, of which £192 14*s.* 10*d.* has been apportioned to the Royal Infirmary, Newcastle.—The Goldsmiths' Livery Company has made a grant of £250 to the Royal Sea-bathing Infirmary for Scrofula, Margate.—The workmen of Messrs. R. and W. Hawthorn, Leslie and Co., Newcastle, have contributed £60 5*s.* for the quarter ending September last to the Newcastle medical charities.—Mrs. H. Wood, late of Bingley, bequeathed £200 to the Bingley Cottage Hospital.—The late General Doria bequeathed £1000 to the Chelsea Hospital for Women.—The Mercers' Livery Company has voted 100 guineas to the Cancer Hospital (Free), Fulham-road, S.W.—The late Mr. Lawson Robinson of St. George's-street bequeathed £100 to the London Hospital and £50 each to the Tower Hamlets Dispensary, the East London Hospital for Children, the City of London Hospital for Diseases of the Chest, and the Royal Hospital for Incurables.—The honorary secretary to the Leeds Musical Festival Committee has sent a cheque for £1300 to the Leeds Infirmary.—The sum of £92 2*s.* 2*d.* has been handed to the treasurer of the Belgrave Hospital for Sick Children, being the proceeds of the united demonstration of the temperance, trade and other societies held in July last in aid of that institution.—The late Mr. Thomas Nelson, publisher, Edinburgh and London, bequeathed £5000 to the Edinburgh Royal Infirmary.—The late Mr. John McCormick bequeathed £500 to the Cripples' Home, Bray, £500 to the City of Dublin Hospital and £500 to the Adelaide Hospital, Dublin.

Appointments.

Successful applicants for Vacancies, Secretaries of Public Institutions, and others possessing information suitable for this column, are invited to forward it to THE LANCET *Office, directed to the Sub-Editor, not later than 9 o'clock on the Thursday morning of each week for publication in the next number.*

ADDENBROOKE, E. H., M.R.C.S., has been appointed Medical Officer for the Wolverley Sanitary District of the Kidderminster Union.

BAINES, E., M.B., B.C. Cantab., has been appointed Second House Physician to the General Infirmary, Leeds.

BRITTON, THOMAS, M.D. St. And., M.R.C.S., D.P.H. Camb., has been reappointed Medical Officer of Health to the Shelf Local Board.

CAMPBELL, JAMES, M.B. Glasg., L.R.C.S. Edin., has been appointed a Public Vaccinator, Clunes, Victoria, Australia.

CLARK, F. W., L.R.C.P. Lond., M.R.C.S., has been appointed, *pro tem.*, Assistant Medical Officer of Health for the Tyne Ports.

CRAVEN, ROB. M., L.R.C.P. Edin., M.R.C.S., has been reappointed Medical Officer of Health for the Westmoreland Combined Sanitary Districts.

CROSLAND, G. W. K., M.R.C.S., L.R.C.P., has been appointed Fourth House Surgeon to the General Infirmary, Leeds.

DUKE, A. F., L.R.C.P., L.M. Edin., M.R.C.S., has been appointed Medical Officer for the Second Sanitary District of the Cheltenham Union, vice Walters, deceased.

EKINS, A. E., has been appointed County Analyst for Hertfordshire.

ENGLISH, T. H., M.R.C.S., L.R.C.P. Lond., L.S.A., has been appointed Junior House Surgeon to the Poplar Hospital for Accidents, East India-road, E.

FIRTH, E., L.S.A., has been appointed Resident Obstetric Officer to the General Infirmary, Leeds.

FOSBROKE, G. H., M.R.C.S., D.P.H. Camb., has been reappointed Medical Officer of Health for the Worcestershire Division of the Alcester Rural Sanitary Authority.

FRASER, D. A., M.D. Brux., M.R.C.S., has been reappointed Medical Officer of Health for the Borough of Totnes.

GORNALL, J. G., M.A., M.B. Cantab., M.R.C.S., L.R.C.P., has been appointed Assistant Medical Officer of Health for the Borough of Warrington and Medical Superintendent of the Hope Hospital for Small-pox.

HAWORTH, JOHN, has been appointed Analyst for the Borough of Tiverton.

HILLIER, T. ERNEST, M.A., M.B. Cantab., M.R.C.S., L.S.A., has been appointed Medical Superintendent to the Infirmary and Medical Officer to the Workhouse of the Parish of Paddington, vice T. Savill, M.D. Lond., resigned.

HODSON, FREDK., M.R.C.S., has been appointed Medical Officer of Health for Hornsea-with-Hornsea, Burton Urban Sanitary District, of the Skirlaugh Union, vice Thompson.

HOGG, G. H., M.B., C.M. Edin., has been appointed Junior House Surgeon to the Clayton Hospital, Wakefield, vice Wait, resigned.

HUGHES, W. L., M.R.C.S., has been reappointed Medical Officer of Health to the Carmarthen Town Council.

JACKSON, JOS. J., L.R.C.P., L.M. Edin., L.R.C.S. Irel., has been appointed Medical Officer of Health for the Rural Sanitary District of the Wakefield Union, vice Walker, resigned.

JEPHCOTT, R. W., L.R.C.P., L.M., L.R.C.S. Edin., has been reappointed Medical Officer of Health for the Warwickshire Division of the Alcester Rural Sanitary Authority.

JOHNSON, WILLIAM, L.R.C.P., L.R.C.S. Edin., has been appointed Health Officer for the Avoca Shire, Victoria, Australia, vice McMahon.

JOHNSTON, T. L., L.R.C.P., L.R.C.S., L.F.P.S. Glasg. & L.M., has been appointed Second Assistant Medical Officer to the Berkshire County Asylum.

KEMMIS, H. M., L.R.C.P. Irel., M.R.C.S., has been appointed Medical Officer to the Union Workhouse, Bridgewater.

KEMPSTER, W. H., M.D. St. And., L.R.C.P., L.M. Edin., M.R.C.S., has been appointed Medical Officer of Health for Battersea.

MACKENZIE, JOHN CUMMING, M.B. &c., has been appointed Deputy Medical Superintendent to the Northumberland County Asylum, Morpeth.

MAY, WM. PAGE, M.D., B.Sc. Lond., M.R.C.S., M.R.C.P., has been appointed Pathologist to the City of London Hospital for Diseases of the Chest, Victoria-park, vice Dr. Chaplin, promoted Assistant Physician.

MARSDEN, R. W., L.R.C.P. Lond., M.R.C.S., has been appointed Assistant Medical Officer for the Workhouse and Receiving Wards of the Township of Manchester, vice Robinson, resigned.

MAYO, A. C., M.R.C.S., L.R.C.P., has been appointed Resident Medical Officer at Ida Hospital.

MOORE, A. J., M.R.C.S., has been reappointed Medical Officer for the St. Lawrence Sanitary District of the Reading Union.

PORTER, CHAS., M.D., B.Ch., B.A.O. Royal Univ. Irel., D.P.H. Camb., M.R.C.S., has been appointed Medical Officer of Health, Physician to the Fever Hospital, and Police Surgeon for the County Borough of Stockport, vice Edwin Rayner, M.D. Lond., F.R.C.S., J.P., resigned.

ROBERTS, R. P., M.R.C.S., has been appointed Medical Officer for the No. 2 Carnarvonshire Sanitary District of the Bangor Union, vice Hughes, deceased.

ROLLASON, A., L.R.C.P. Lond., M.R.C.S., has been appointed Health Officer for the Eltham Shire, Northern and Southern Ridings, Victoria, Australia, vice James, deceased.

SCOTT, BERNARD, M.R.C.S., has been appointed Surgeon to the In patients of the Royal Victoria Hospital, Bournemouth.

SCRATCHLEY, R. W., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Third Sanitary District of the Poole Union.

SNELL, S. H., M.B. Lond., L.R.C.P., M.R.C.S., has been appointed Medical Officer for the Grays Thurrow Urban Sanitary District of the Orsett Union, vice Stirling, resigned.

THEED, WM. C., M.R.C.S., has been appointed a Public Vaccinator, Allansford, Victoria, Australia.

TILLEY, HERBERT, M.D., B.S. Lond., M.R.C.S., L.R.C.P., has been appointed House Surgeon to the London Throat Hospital.

WHITEHEAD, A. L., M.B.Lond., has been appointed Third House Surgeon to the General Infirmary, Leeds.
YOUNG, JAMES M., M.B., C.M. Aberd., has been appointed Ophthalmic Surgeon to the West Bromwich District Hospital.

Vacancies.

For further information regarding each vacancy reference should be made to the advertisement.

BRIGHTON, HOVE AND PRESTON DISPENSARY.—House Surgeon to the Western Branch. Salary £140 per annum (less board at 8s. per week), with furnished apartments, coals, gas and attendance. (Applications to the Assistant Secretary, Queen's-road, Brighton.)
EAST LONDON HOSPITAL FOR CHILDREN, Glamis-road, Shadwell, E.—House Physician. Board and lodging provided.
GLAMORGAN COUNTY COUNCIL.—County Medical Officer. Salary £760 per annum, of which £150 is intended to cover all travelling and office and laboratory expenses.
HOSPITAL FOR SICK CHILDREN, Great Ormond-street, W.C.—Ophthalmic Surgeon.
HOSPITAL FOR SICK CHILDREN, Great Ormond-street, W.C.—House Surgeon for six months. Salary £25, board and residence in the hospital.
HOSPITAL FOR SICK CHILDREN, Great Ormond-street, W.C.—Assistant Physician.
METROPOLITAN ASYLUMS BOARD.—Assistant Medical Officer for the North-Eastern Hospital, St. Ann's-road, Stamford-hill, N. Salary £15 per month, with board, lodging and washing. (Applications to the Clerk to the Board, Norfolk House, Norfolk-street, Strand, W.C.)
METROPOLITAN HOSPITAL, Kingsland-road, N.E.—Assistant Surgeon and Assistant Physician.
ROYAL COLLEGE OF SURGEONS OF ENGLAND.—Examiner in Anatomy for the Second Professional Examination.
ROYAL INFIRMARY, Edinburgh.—Superintendent. Salary £500 per annum, with free house, coal and gas.
ST. MUNGO'S COLLEGE, Glasgow.—Chair of Anatomy.
THE CANCER HOSPITAL (Free), Fulham-road, S.W.—House Surgeon for six months. Salary at the rate of £50 per annum, with board and residence.
THE NEW LONDON COUNTY ASYLUM, Claybury, Woodford, Essex.—Medical Superintendent. Salary £1000 per annum, with house, coals, lighting, milk and vegetables.
THE GUARDIANS OF PADDINGTON.—Assistant to the Medical Superintendent of the Infirmary and Assistant Medical Officer of the Workhouse. Salary £100 per annum, rising £10 annually to £120, together with board, lodging and washing. (Applications to the Medical Superintendent at the Infirmary, 285, Harrow-road, N.W.)

Births, Marriages and Deaths.

BIRTHS.

DINGLEY.—On Oct. 28th, at 11, Upper Woburn-place, the wife of Allen Dingley, F.R.C.S., of a son.
GRINDON.—On Oct. 26th, at Olney, Bucks, the wife of F. J. Grindon, M.R.C.S., of a daughter.
GODFREY.—On Oct. 28th, at Bridlington Quay, Yorkshire, the wife of H. J. Clarendon Godfrey, of a daughter.
HOWSE.—On Oct. 26th, at Brook-street, Grosvenor-square, W., the wife of H. G. Howse, M.S., F.R.C.S., of a daughter.
HUMPHREYS.—On Oct. 25th, at Dyke-road, Brighton, the wife of J. H. Humphreys, M.D. Lond., of a son.
SANDBERG.—On Oct. 27th, at Liverpool Lodge, Brixton-hill, S.W., the wife of Arthur G. Sandberg, M.D., of a daughter.
WALSH.—On Oct. 28th, at Naval-terrace, Sheerness, the wife of Dr. J. J. Walsh, R.N., H.M.S. *Bramble*, of a son.
WHITE.—On Oct. 27th, at 144, Sloane-street, S.W., the wife of C. Percival White, M.A., M.B., B.C., of a daughter.

MARRIAGES.

LAWSON—ROBERTS.—On Oct. 26th, at the Parish Church, Tottenham, by the Very Rev. the Dean of Lincoln, assisted by the Rev. N. G. Lawson, M.A., brother of the bridegroom, Hugh Lawson, third son of William Norton Lawson, of 19, Dorset-square, to Sarah Alice, third daughter of the late David Roberts, of Cavendish House, Tottenham.
MATHESON—DAWSON.—On Saturday, the 29th ult., at St. George's, Charlotte-square, Edinburgh, by the Rev. Archibald Scott, D.D., Angus Matheson, M.D., North Berwick, to Helen Ramage, younger daughter of the late William Dawson, Esq., Distiller, Linlithgow.
MORRICE—ELLEMENT.—On Oct. 29th, at Wyke Regis Church, Dorset, George Gavin Morrice, M.A., M.D. Cantab., M.R.C.P., youngest son of the Rev. William David Morrice, to Alice Amelia, youngest daughter of the late John Josiah Ellement.
ORCHARD—SCOTT.—On Oct. 26th, at the Baptist Chapel, Ashby-de-la-Zouch, by the Rev. C. Rushby, assisted by the Rev. T. A. Plant, B.A., Alfred Orchard, M.R.C.S. and L.R.C.P. Lond., son of Mr. George Orchard, to Sarah Emily (Sadie), eldest daughter of Mr. Richard Scott of the same town.
SAWYER—CLEGG.—On Oct. 27th, at St. Mary's Parish Church, Stockport, by the Rev. Canon Symonds, Ramon Alexander Sawyer, L.R.C.P., M.R.C.S., second son of the Hon. R. H. Sawyer, of Nassau, N.P., Bahamas, to Sarah Alice (Solace), eldest daughter of the late Edward Clegg, J.P., of Oldham and Brinnington Lodge, Stockport.

DEATHS.

BRADLEY.—On Oct. 31st, at Park-terrace, Nottingham, Chas. Bradley, F.R.C.S., aged 51.
GEORGE.—On Oct. 27th, at Port Isaac, Cornwall, Katherine Wylie, the beloved wife of R. Julyan George, M.B., C.M. Edin., aged 26 years.
HARLE.—On Oct. 31st, at St. George's-terrace, Lower Edmonton, Charles Ebenezer Harle, L.R.C.P.Ed., late of the Bank of England, in his 85th year.
LOWE.—On Oct. 30th, at Burton-on-Trent, George Lowe, J.P., F.R.C.S., aged 79.
LOWNDS.—On Oct. 31st, at Wateringbury, Kent, Thomas Mackford Lownds, M.D., Surgeon-Major, Retired, H.M.I.A., and late of Egham, Surrey, aged 64.
ROBERTSON.—On Oct. 31st, at Ajaccio, Corsica, Dr. John Chalmers Robertson, of Glenshee Lodge, Wandsworth-common, in the 53rd year of his age.
SANDERS.—On Oct. 30th, at Upper Fant-road, Maidstone, Godfrey Sanders, Surgeon, aged 76.
SMYTH.—At Magdalene-road, St. Leonards, William Dickson Smyth, M.D., Staff-Surgeon Royal Navy, aged 57.

BOOKS ETC. RECEIVED.

CHURCHILL, J. & A., New Burlington-street, London.
Eye-strain (commonly called Asthenopia). By Ernest Clarke, M.D., B.S. Lond. Illustrated. 1892. pp. 168.
The Climate of Rome and the Roman Malaria. By Professor Tommasi-Crudeli. Translated by C. C. Dick. 1892. pp. 163.
Commercial Organic Analysis. By A. H. Allen, F.I.C., F.C.S. Second Edition. Vol. III., Part II. 1892. pp. 584.

HARRISON & SONS, St. Martin's-lane, London.
The Collected Papers of Sir William Bowman, Bart., F.R.S. "Bowman Testimonial Fund." Edited by J. Burdon-Sanderson, M.D., F.R.S., and J. W. Hulke, F.R.S. Vols. I. and II. 1892.

LEWIS, H. K., Gower-street, London.
Epidemic Influenza. A Study in Comparative Statistics. By F. A. Dixey, M.A., D.M. With Diagrams and Tables. 1892. pp. 29.
A Handbook of the Diseases of the Eye and their Treatment. By H. R. SWANZY, A.M., M.B., F.R.C.S. Irel. Fourth Edition. Illustrated. 1892. pp. 536.
Hygiene and Public Health. By Louis C. Parkes, M.D. Third Edition. Illustrated. 1892. pp. 523.
Treatise on the Diseases of Women. By Alexander J. C. Skene, M.D. Second Edition. 1892. pp. 968.

LIVINGSTONE, E. & S., Edinburgh.
Anatomy of the Brain and Spinal Cord. By J. R. Whitaker. Second Edition. 1892. pp. 173.
The Rotatory Movements of the Human Vertebral Column and the so-called Musculi Rotatores. By Alfred W. Hughes, M.B. Edin., F.R.C.S. Eng. 1892. pp. 35.

PENTLAND, YOUNG J., Edinburgh and London.
The Diseases of the Stomach. By Dr. C. A. Ewald. Translated from the Second German Edition by Morris Manges, A.M., M.D. Illustrated. 1892. pp. 497.

PHILIP, GEO., & SON, London and Liverpool.
"The" Practical Guide to Algiers. By Geo. W. Harris. Third Edition. 1893. pp. 176. Price 3s. 6d.

RUEFF ET CIE., Paris.
Les Troubles de la Marche dans les Maladies Nerveuses. Par Paul Blocq.

SCOTT, WALTER, Warwick-lane, Paternoster-row, London.
Public Health Problems. By J. F. J. Sykes, B.Sc. (Public Health), M.B. Edin. Illustrated. 1892. pp. 370.

SIMPKIN, MARSHALL & CO., London.
An Order to View. By Lotha Yaladuam. 1892. pp. 320.

SWAN SONNENSCHEIN & CO., Paternoster-square, London.
Introduction to Physiological Psychology. By Dr. T. Zichen. Illustrated. 1892. pp. 184.
Text-book of Elementary Biology. By H. J. Campbell, M.D.Lond. Illustrated. 1893. pp 284.

WILLIAMS & NORGATE, Henrietta-street, Covent-garden, London.
Specielle Chirurgie für Aerzte und Studirende. Von Prof. Dr. H. Fischer. 1892.

Catalogue of Surgical Instruments and Appliances (sold by P. Harris & Co., Birmingham).—Is Katatonia a Special Form of Mental Disorder? and Cases of so-called Katatonia; by M. J. Nolan, L.R.C.P., L.R.C.S. Irel., M.P.C. (South Counties Press, Lewes, 1892).—Fever Nursing; by Mary Harris (The Record Press, London); price 1s.—Abstract of the Transactions of the Hunterian Society, Session 1891-92, with the Report of the Council, and the Annual Oration for 1892 (Ash & Co., London).—Archives of Surgery, October, 1892 (J. & A. Churchill, London).—Higiene de los Nervios; por Hugo Marcus (Felix Lajouare, Buenos Aires, 1892).—Hydro-naphthol in the Prophylaxis and Treatment of Cholera: Report of Laboratory Experiments; by D. D. Stewart, M.D.; reprint from the Medical News, Oct., 1892 (Lea Brothers & Co., Philadelphia).—Transactions of the Obstetrical Society of London, Vol. XXXIV., for the year 1892; Part XI. for March, April, and May (published by the Society, Hanover-square, London).—On Reinfection in Phthisis; by A. Ransome, M.D. Cantab., F.R.S.; reprint (J. Heywood, Manchester and London).—Philosophical Transactions of the Royal Society of London, Vol. CLXXXIII. (Kegan Paul, Trench, Trübner & Co., London); price 5s. 6d.—The Veterinary Journal; edited by George Fleming, C.B., LL.D., F.R.C.V.S., November, 1892 (Baillière, Tindall & Cox, London); price 1s. 6d.—Étude sur le Climate de Pau, et du Sud-Ouest Français; par le Dr. E. Duhourcau (Edouard Privat, Toulouse).—Magazines for November: Sunday at Home, Leisure Hour, Boy's Own Paper, Boy's Out-door Games and Recreations, Girl's Own Paper, Girl's Own Out-door Book (Religious Tract Society).

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET Office, Nov. 3rd, 1892.

Date.	Barometer reduced to Sea Level and 32° F.	Direction of Wind.	Dry Bulb.	Wet Bulb.	Solar Radia in Vacuo	Maximum Temp. Shade.	Min. Temp	Rainfall.	Remarks at 8.30 A.M.
Oct. 28	29·34	S.W.	50	57	65	59	41	·32	Cloudy
,, 29	29·36	S.W.	58	56	79	60	56	·33	Cloudy
,, 30	29·74	E.	49	47	68	56	43	·09	Cloudy
,, 31	29·69	N.E.	48	47	..	48	47	1·24	Raining
Nov. 1	29·84	N.E.	45	43	56	50	43	·06	Overcast
,, 2	29·86	N.E.	36	36	58	53	35	..	Foggy
,, 3	29·65	S.W.	51	50	80	55	36	·12	Overcast

Medical Diary for the ensuing Week.

Monday, November 7.

KING'S COLLEGE HOSPITAL.—Operations, 2 P.M.; Fridays and Saturday, at the same hour.

ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1.30 P.M., and on Tuesday, Wednesday, Friday, and Saturday at the same hour.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations daily at 10 A.M.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1.30 P.M., and each day at the same hour.

CHELSEA HOSPITAL FOR WOMEN.—Operations, 2 P.M.; Thursday, 2

HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M., and on Thursday at the same hour.

METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.

ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.

CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and each day in the week at the same hour.

UNIVERSITY COLLEGE HOSPITAL.—Ear and Throat Department, 9 A.M.; Thursday, 9 A.M.

LONDON POST-GRADUATE COURSE.—Royal London Ophthalmic Hospital: 1 P.M., Mr. W. Lang: Diseases of Cornea.—101, Gt. Russell-st.: 8 P.M., Dr. Galloway: Gastro-intestinal Tract.—Parkes Museum (Margaret-st., W.): 4 P.M., Dr. Louis C. Parkes: Dwelling Houses.

THROAT HOSPITAL (Golden-sq.).—5 P.M. Dr. James W. Bond: Nasal Polypus.

MEDICAL SOCIETY OF LONDON.—8.30 P.M. Mr. Bland Sutton: Tubal Moles and Tubal Abortion.—Mr. Marmaduke Sheild: A second communication on Arterial Hæmorrhage from Ulcerating Bubo of the Groin.

Tuesday, November 8.

GUY'S HOSPITAL.—Operations, 1.30 P.M., and on Friday at the same hour. Ophthalmic Operations on Monday at 1.30 and Thursday at 2 P.M.

ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 4 P.M.; Friday, 2 P.M.

ST. MARK'S HOSPITAL.—Operations, 2 P.M.

CANCER HOSPITAL, BROMPTON.—Operations, 2 P.M.; Saturday, 2 P.M.

WESTMINSTER HOSPITAL.—Operations, 2 P.M.

WEST LONDON HOSPITAL.—Operations, 2.30 P.M.

ST. MARY'S HOSPITAL.—Operations, 1.30 P.M. Consultations, Monday, 2.30 P.M. Skin Department, Monday and Thursday, 9.30 A.M. Throat Department, Tuesdays and Fridays, 1.30 P.M. Electrotherapeutics, same day, 2 P.M.

LONDON POST-GRADUATE COURSE.—Hospital for Skin Diseases, Blackfriars: 4 P.M., Dr. Payne: Eczema, its Varieties.—Bethlem Hospital: 2 P.M., Dr. H. Corner: Puerperal and Lactational Insanity.—101, Gt. Russell-st., W.C.: 8 P.M., Dr. Herman: Painful Micturition in the Female.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.—Mr. H. G. Howse: On the Advantages of an Amputation through the Thigh, either as a Preliminary Operation to or in some cases instead of Amputation through the Hip, where the Hip-joint is itself diseased and the Patient in very bad condition.—Mr. R. Lawford Knaggs: Two cases illustrating the Treatment of Advanced Hip-joint Disease by Mr. Howse's Method of Preliminary Amputation near the Knee (communicated by Mr. Howse).

Wednesday, November 9.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.

MIDDLESEX HOSPITAL.—Operations, 1.30 P.M.; Saturdays, 2 P.M. Obstetrical Operations, Thursdays, 2 P.M.

CHARING-CROSS HOSPITAL.—Operations, 3 P.M., and on Thursday and Friday at the same hour.

ST. THOMAS'S HOSPITAL.—Operations, 1.30 P.M.; Saturday, same hour.

LONDON HOSPITAL.—Operations, 2 P.M.; Thursday & Saturday, same hour.

ST. PETER'S HOSPITAL, COVENT-GARDEN.—Operations, 2 P.M.

SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2.30 P.M.

GREAT NORTHERN CENTRAL HOSPITAL.—Operations, 2 P.M.

UNIVERSITY COLLEGE HOSPITAL.—Operations, 1.30 P.M.; Skin Department, 1.45 P.M.; Saturday, 9.15 A.M.

ROYAL FREE HOSPITAL.—Operations, 2 P.M., and on Saturday.

CHILDREN'S HOSPITAL, GREAT ORMOND-STREET.—Operations, 9.30 A.M. Surgical Visits on Wednesday and Saturday at 9.15 A.M.

LONDON POST-GRADUATE COURSE.—Hospital for Consumption, Brompton: 4 P.M., Dr. Pollock: Some Varieties of Phthisis.—Royal London Ophthalmic Hospital: 8 P.M., Mr. A. Quarry Silcock: Glaucoma.

THROAT HOSPITAL (Golden-sq.).—5 P.M. Mr. T. Mark Hovell: Middle Ear Disease.

HUNTERIAN SOCIETY (London Institution).—8.30 P.M. Dr. Patrick Manson: Cases of Beriberi (?).—Dr. G. E. Herman: "Champelier de Ribes" Bag for Inducing Labour.—Dr. Ettles (for Dr. Cotman) will show a Man with Superficial Ulceration of the Popliteal Space.—Mr. F. R. Humphreys: Notes of Two cases of Cheyne-Stokes Respiration, with recovery.—Dr. A. T. Davies: A case of Graves' Disease.—Dr. Hingston Fox: A case of Incomplete Graves' Disease, with Stellways' and Von Graefe's Symptoms.—Dr. Arnold Chaplin: Two cases of Fibroid Disease of the Lungs.—Mr. J. Poland: Cured Congenital Cyst of Neck.—Dr. Thos. Marshall: Local Sweating of the Face. And other cases.

Thursday, November 10.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M. Surgical Consultations Wednesday, 1.30 P.M. Ophthalmic Operations, Friday, 1.30 P.M.

UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M.; Ear and Throat Department, 9 A.M.

LONDON POST-GRADUATE COURSE.—Hospital for Sick Children, Great Ormond-st.: 4 P.M., Dr. D. B. Lees: Demonstration of Medical Cases in the Wards.—National Hospital for the Paralysed and Epileptic: 2 P.M., Dr. Tooth: The Diagnosis between Functional and Organic Disease of the Nervous System.—London Throat Hospital, Gt. Portland-st.: 8 P.M., Dr. E. Law: Demonstration of Cases.—Central London Sick Asylum, Cleveland-st., W.: 5.30 P.M., Dr. Ord: Medical Cases in the Wards.

BRITISH GYNÆCOLOGICAL SOCIETY (20, Hanover-sq.).—8.30 P.M. Dr. Granville Bantock: Specimens of Molluscum Fibrosum, Fibroma of the Ovary, and Uterine Fibro-myoma.—Mr. G. Burford: Specimens of Extra-uterine Gestation and Large Ovarian Tumour.—Dr. Inglis Parsons: Total Absorption of a large Fibro-myoma of the Uterus by Apostoli's Treatment.

NORTH LONDON MEDICAL AND CHIRURGICAL SOCIETY.—Clinical Evening. Cases shown by Dr. Lewis Jones, Mr. Gordon Brodie, Dr. F. Spicer, Dr. Malcolm, Dr. Case and others.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.—8.30 P.M. Patients and Card Specimens at 8 P.M. Mr. H. Word Dodd: A case of Aniridia.—Mr. Hartridge: (1) Rupture of the Choroid; (2) Patient with Aniridia.—Dr. Berry: (1) Conjunctivitis set up by Flies; (2) Hyperplastic Sub-conjunctivitis; (3) Intra-ocular Therapeutics; (4) Intra-ocular Absorption of Iodoform. And other papers.

Friday, November 11.

ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.

LONDON POST-GRADUATE COURSE.—Hospital for Consumption, Brompton: 4 P.M., Dr. Symes Thompson: Catarrhal Phthisis.—Bacteriological Laboratory, King's College: 11 A.M. to 1 P.M., Professor Crookshank: Actinomycosis (Sections).

CLINICAL SOCIETY OF LONDON.—Mr. Lawford Knaggs: The Conditions seen at an Operation for Ventral Hernia five years and a half after Laparotomy for Tubercular Peritonitis.—Dr. Handford: A case of Hyperplastic (Obliterating) Phlebitis affecting the Larger Veins.—Mr. Donald Day (introduced by Mr. Howard Marsh): Case of Nephrolithotomy; large Calculus.—Dr. Walter Carr: A case of Double Empyema; Simultaneous Drainage of the Pleural Cavities; recovery.

Saturday, November 12.

UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M.; and Skin Department, 9.15 A.M.

LONDON POST-GRADUATE COURSE.—Bethlem Hospital: 11 A.M., Dr. Percy Smith: Alcoholic Insanity.

Notes, Short Comments & Answers to Correspondents.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

All communications relating to the editorial business of the journal must be addressed "To the Editors."

Lectures, original articles, and reports should be written on one side only of the paper.

Letters, whether intended for insertion or for private information, must be authenticated by the names and addresses of their writers, not necessarily for publication.

We cannot prescribe or recommend practitioners.

Local papers containing reports or news paragraphs should be marked and addressed "To the Sub-Editor."

Letters relating to the publication, sale, and advertising departments of THE LANCET *to be addressed "To the Publisher."*

We cannot undertake to return MSS. not used.

A MODERN SCIENTIFIC DISCUSSION.

"—— Animis Cœlestibus Iræ!"

Miss Fanny (a gentle and most veracious child): "Yah, you cruel coward! you and your friends skinned a live frog!"

Master Victor (an industrious but very touchy little Boy): "You're a liar! The frog was dead, and you know it!"

Miss Fanny: "Boohoo! Whether it was dead or not, you've got no right to call names; 'cos I'm a girl, and can't punch your head."

Master Victor: "It's just because you're a girl that I can't punch yours! You should have thought of that before you called me a coward!"

Punch.

W. H. C.—Assuming the correctness of our correspondent's statement that the appointment rests with the Home Secretary, the course he suggests would certainly be advisable, but we would advise him to make careful inquiry as to whether the appointment does not now rest with the County Council.

Mr. Ralph Cann (Plymouth).—The observations of our correspondent are not new. They have been made and described many years ago by Helmholtz, and he will find a very similar description of the phenomena in Jago's Entoptics (Churchill, 1864).

Mr. C. J. Rawlings.—An abstract of the address will be found in THE LANCET of Oct. 8th, 1892.

"THE MEDICAL JOURNALS AND INFAMOUS CONDUCT."

THE *Food, Drugs and Drink Journal*, while approving our protest against those who lend themselves to medical aid associations on undignified and ruinous terms, complains that we have no censure for men of eminence in the profession, who are always ready to give testimonials for "anybody's soap, cocoa, mustard," and every rubbishy, much-advertised article. We are not prepared to admit this charge. Let our contemporary give instances with details more carefully, and we shall not fail to say what we think. We are quite of opinion that there is too much readiness to write testimonials that greatly mislead the public, and that the evil needs strong treatment.

Mr. Edwin Hegan, M.B., B.Ch.—We do not know of any work on physiology which discusses the subject alluded to by our correspondent. But such a division might be made in several ways—as, topographically, into head, body and extremities; or, histologically, into nervous, vascular, glandular, osseous and muscular systems; or, embryologically, into tissues derived from epi-, meso- and hypoblast respectively; or, functionally, into organs of secretion, sensation, motion, support, digestion, reproduction, and the like.

D.P.H. Camb. will probably find all the information he requires in "Sewage Treatment, Purification and Utilisation," by J. W. Slater, published by Messrs. George Bell and Sons.

CLERICAL INTERFERENCE WITH MEDICAL DUTIES.

To the Editors of THE LANCET.

SIRS,—Some two months ago I was called to a case of typhoid fever existing in ——. In the usual course I notified this disease to the medical officer of health of the district. The sanitary inspector called at the house, and amongst other directions instructed the inmates that they were not to send the only child (not the patient) to school, that none of the inhabitants of the house were to go to church, and gave a mass of other instructions, and finally left a certificate for me to fill up, to state when the patient had finished desquamating, so that disinfection could be properly carried out—all of which directions were of course very right and proper if it had been a case of scarlet fever and not typhoid fever, which it was notified in my certificate to be. I wrote to the medical officer of health pointing out this, and saying that I thought his sanitary officer must have made a mistake as to the nature of the disease. I received a courteous reply from him, agreeing with my letter to him, but not laying any blame on his officer, as was perhaps quite natural, and there I supposed the matter had ended. I am sorry to say I did not keep the medical officer's letter to me, but the above was the tenour of it. Judge, then, of my surprise when I received this morning the following letter (I may say that the case occurred in an adjoining parish and that I had never once seen the Rev. ——, though I had heard his name before):—

[COPY.] "Oct. 28th, 1892.

"SIR,—I learn that you have been the medical attendant on a person named ——, residing at —— Farm, ——, in the parish of ——, during the latter part of last month; that you notified Dr. ——, *who in turn notified me* [the italics are mine] on Sept. 19th last of the infectious character of the disease (typhoid fever) from which the said —— was suffering; that you afterwards denied the fact of your having notified the medical officer of the district; and that you represented it to be impossible that I could have *received a notification* [the italics are mine], as none had been sent. Before any further action is taken in this matter I shall be glad to hear what you have to say.

"I am, yours truly,

"Dr. ——." "——, Vicar of ——.

[ANSWER.] "Oct. 29th, 1892.

"SIR,—As a matter of courtesy only do I take the least notice of your impertinent letter dated Oct. 28th, 1892. I deny your right in any way whatever to catechise me as to what I have done, or what I have not done in my medical capacity. I notified to the proper authority that a disease (scheduled under the Infectious Diseases Notification Act) existed at ——, and therein fulfilled the duty required of me by the law; nor have I so far stultified myself as to deny what I had already recorded in writing and sent to the authority properly constituted for the reception of such intelligence. I decline to answer or in any way notice any further communication from you on this subject.

"I am, yours truly,

"The Rev. ——, Vicar of ——." "——.

"THE OWNERSHIP OF PRESCRIPTIONS."

To the Editors of THE LANCET.

SIRS,—Will you allow me (as a dispensing chemist) to point out to your correspondent, "H. S. F.," the fact that the druggist has no power to refuse to dispense any prescription presented to him if it is properly signed. I believe that every dispenser would prefer to dispense a fresh prescription than an old one repeatedly; the remedy rests entirely with the profession. The prescriber should write on the bottom of the prescription, "This prescription must not be dispensed after——," but this would have to be written in Latin, or the patient would probably tear it off as unimportant. It would then be an easy thing for the druggist to explain to the patient that the doctor did not intend any more of that medicine to be taken, and that he must go and consult him again.

I am, Sirs, yours faithfully,

Oct. 26th, 1892. A. A. B.

A NOTEWORTHY BEQUEST BY AN EDINBURGH DOCTOR.

AMONGST the legacies bequeathed by the late Dr. William Fullarton Cumming, Kinellan, Murrayfield, Edinburgh, is the following:—To the managers of the Royal Infirmary of Edinburgh, £600, but only on the condition of their undertaking to invest the same and apply the annual income thereof in the purchase of snuff and tobacco for the use of such poor patients, male and female, as may be admitted into the infirmary on account of fractures, dislocations, scalds, ulcers and other chronic maladies, and who have been addicted to the use of tobacco in any shape and are known to be in distress from the want of it; or the managers may use such part of the income as they may think right from time to time in the purchase of tea and sugar for the use of such of those patients as may prefer tea and sugar to snuff and tobacco. In a separate paper, in his own handwriting, Dr. Cumming says:—"In my youth I was a dresser in the Infirmary of Edinburgh, and often had occasion to witness, and always the desire to relieve, the distress arising from inability on the part of the poorer patients to provide themselves with a long-accustomed gratification; and having been for more than twenty years of my life a slave to the use of tobacco, I know how to feel for the suffering of those who, in addition to the irksomeness of pain and the tedium of confinement, have to endure the privation of what long habit had rendered in a great degree a necessary of life. To some the bequest will appear whimsical and eccentric. No votary of tobacco will be of this opinion. I have no wish to teach bad habits, but it is my desire that the bequest be strictly carried into effect."

Inquirendus.—It is useless applying to the Local Government Board for superannuation, unless the board of guardians have recommended it on the resignation of the medical officer. It is the best policy to sound the guardians privately upon the subject before resigning. The recommendation of the guardians is seldom refused by the Local Government Board. We trust in time to obtain compulsory superannuation for Poor-law medical officers of long standing.

Mr. John E. Allen.—We see no reasonable objection to the circular, if couched and distributed in a strictly private manner to *bond-fide* patients.

Mr. B. H. Thwaite is thanked for his communication, but the subject of the paper and the analytical statistics therein have already been dealt with in our columns.

"THE HISTORY OF QUACKS AND QUACKERY."

To the Editors of THE LANCET.

SIRS,—Your correspondent "A" will find, on turning to Defoe's "Journal of the Plague in London," in Nimmo's edition of Defoe's works, on pages 460 and 461, a very graphic description of *medical* quacks and their ways, given as none but Defoe could give. If "A" be not already aware of the fact, let me inform him that Defoe was born in 1661, and that he was but four years old when the Great Plague occurred. Moreover, the celebrated Dr. Mead was said to have been "taken in" by the work of Defoe, as the descriptions Defoe gives are so realistic that it is hard to believe he was not really present during the Plague and really heard the bellman's cries and saw the dead cart coming round. "A" will find quacks referred to in other parts of the work. *Apropos* of this subject, I find that Chambers's "Etymological Dictionary" states that the word "quack" is derived from the cry of the duck.

I am, Sirs, yours obediently,

LEONARD KIDD, L.R.C.P. Edin. &c.

George-street, W., Oct. 31st, 1892.

A MEDIÆVAL REMNANT.

To the Editors of THE LANCET.

SIRS,—The following inscription, which is from a notice affixed to the portal of a doctor's residence at Trani, in Southern Italy, and may be found in Ross's "Land of Manfred," London, 1889, may interest your readers, and perhaps be of value to the scientists who compile the annual supplement to the British Pharmacopœia:—"Professor Ricca.—The said Professor Ricca will use for making his salves live snakes and large serpents, wolves, bears, monkeys, marmots, weasels, and numerous other kinds of wild animals, alive and in good condition." ("Il medicino Professore Ricca, per fare i suoi unguenti, comperà serpenti e serpi grossi vive: lupi, orsi, scimie, marmotti, faine e tante altre razze di animali selvaggi vivi e sani.")

I am, Sirs, yours faithfully,

London, Oct. 1892. J. OFFORD, junior, M.S., B.A.

"PECULIAR SYMPTOMS OF POISONING BY SANTONIN."

To the Editors of THE LANCET.

SIRS,—The case "M.R.C.S." reported in your last issue (p. 1031) does not apparently greatly differ from many of the cases noted in the Medical Digest, Section 397: 4, or from the effects produced in one of my own children many years ago in Batavia, upon which occasion I was as much alarmed as "M.R.C.S."

I am, Sirs, yours obediently,

Boundary-road, N.W., Oct. 29th, 1892. RICHD. NEALE, M.D. Lond.

COMMUNICATIONS not noticed in our present issue will receive attention in our next.

Communications, Letters, &c., have been received from—

A.—Dr. F. H. Alderson, Leicester; Dr. J. Althaus, London; Messrs. Anderson and Co., Edinburgh; Mr. Alexander, Dublin; The Editor, *Asiatic Quarterly Review.*

B.—Sir J. Crichton Browne, London; Mr. Bryant, London; Dr. J. Bull, Kent; Messrs. Bates, Hendy and Co., London; Dr. Burton, London; Messrs. Brady and Martin, Newcastle-on-Tyne; Mr. Butler, Retford; Mr. Binde, Hyderabad; Mr. Bulger, Wolverhampton; Messrs. Brown, Gould and Co., London; *Birmingham Daily Post* Office.

C.—Dr. J. Cameron, Bristol; Mr. Crowe, Norwich; Mr. H. Cave, Kent; Mr. W. Watson Cheyne, London.

D.—Dr. Davis, Kent; Dr. Dixey, Malvern; Mr. W. Dash, London; Surg.-Lieut.-Col. S. L. Dobie, Madras; Mr. Dobbs, Folkestone; Mr. Thos. Dickson, London; Mr. Dalton, Dorchester; Mr. Wm. Dobbins, Ireland; D.; Divide et Impera; D. B., London.

F.—Dr. FitzGerald, Folkestone; Mr. J. E. Jeaffreson, Framlingham.

G.—Mr. Glendinning, Newcastle; Mr. R. Graham, London; Mr. Glanville, Welshpool; Mr. Gray, Dublin; Mr. E. F. Gardner, Ilfracombe; Mr. Gent, Bucks; Mr. Upcot Gill, London; General Practitioner.

H.—Dr. W. Horman, Winchester; Dr. G. Hay, Pittsburg, U.S.A.; Dr. R. M. Horne, Edinburgh; Mr. D. F. Haringan, London; Dr. E. Hegan, Southampton; Mr. Humphreys, London; Mr. Heywood, Manchester; Messrs. Hill and Boll, Yeovil; Messrs. Hadden and Co., London.

I.—Messrs. Isaacs and Co., London; Inquirendus; Income Tax Repayment Co.

J.—Dr. Hughlings Jackson, London; Mr. F. Jessett, London; Dr. F. F. Jay, Kent; Joint Stock Co.'s Information Bureau, London.

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